"Being in a Funk": Teens' Efforts to Understand Their Depressive Experiences

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Although there is literature about adults' experiences of depression, little research has focused on teenagers' experiences. In this article, the authors describe how a sample of adolescents makes sense of depression and responds to a depression diagnosis. Twenty-two adolescents participated in in-depth individual or focus group interviews. Teens discussed their experiences with depression and getting health care for depression, and described a trajectory similar to that found among adults: a slow growth of distress, a time of being in a funk, and a time of consideration of whether they are depressed. Teens who received a diagnosis from a medical provider then sought to make sense of their depression. Teens understood a depression diagnosis as a helpful label, a chronic medical problem, or a significant part of their identity. Understanding the subjective experience of adolescents who are depressed might increase health care providers' empathy and improve their communication with teens.

Keywords: *depression; adolescents; treatment; attitudes; primary care; meaning*

The ways in which individuals conceptualize symptoms, in combination with their subjective experiences of emotional difficulties, influence whether they seek medical treatment and adhere to physician recommendations (Becker, 1974; Rogers, May, & Oliver, 2001). Such experiences can be particularly important among adolescents, whose developmental stage places them at high risk for not seeking mental health treatment (Logan & King, 2001). Although depression is the most common diagnosis applied to teenagers seeking mental health services (Aseltine, Gore, & Colten, 1994), depressed teens tend to obtain professional treatment for depression at rates far below the prevalence of the disorder (Hirschfeld et al., 1997; Logan & King, 2001; Wu et al., 1999). Low service use is likely related to numerous teen-specific barriers to treatment, such as concerns about parent involvement and the meaning of a mental illness diagnosis on a developing identity (Wisdom, Clarke, & Green, 2003).

Teens who recognize they are in distress but do not conceptualize their distress as depression are likely to choose nonmedical means of distress relief (Wisdom

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et al., 2003). In addition, those who accept the term *depression* as congruent with their experiences are likely to experience shifts in self-image and identity that might affect their current or future functioning, and their follow-through with health care (Estroff, Lachichotte, Illingsworth, & Johnston, 1991; Rogers et al., 2001). Finally, how individuals obtain medical care, in combination with how they integrate depression into their identity, can affect adherence to medical interventions and outcomes (Rogers et al., 2001).

In general, the development of depression often includes sufferers' attempts to identify a cause for their symptoms (situational vs. organic). Irrespective of this determination, seeking treatment and directly addressing the issue might exacerbate the discomfort in both "illness identity" and the search for explanations (Estroff et al., 1991). Given the loss of self associated with depression and the impossible task of disassociating the self from the condition (Rogers et al., 2001), obtaining a diagnosis of depression might be particularly difficult for adolescents who are in the process of maturing and do not want a "mentally ill" identity (Charmaz, 1997; Karp, 1994; Wisdom et al., 2003).

Although literature is growing about adults' process of seeking treatment and integrating depression into their identity (e.g., Gammell & Stoppard, 1999; Schreiber, 1998) and how identity is affected by antidepressant use (Knudsen, Hansen, Traulsen, & Eskildsen, 2002; Venarde, 1999), we were unable to find explorations of teenagers' experiences of depression. Questions remain about the ways in which teens make sense of their depression, and about whether their learning processes in this arena differ from those of adults. Understanding these experiences might help improve depression prevention, identification, and intervention.

In this article, we describe how adolescents who have been diagnosed with unipolar depression experience, interpret, and understand a condition that has a significant effect on their daily activities, relationships, and identity. We specifically address teens' processes of coming to terms with explanations for their experience and how they interpret medical diagnoses, and we provide a theoretical framework for further analysis.

METHOD

To understand teens' experiences of depression, we used a modified grounded theory approach based on the work of Strauss and Corbin (1998). Grounded theory permits participants to present their experience in their own words and enables development of theory based on the variability of participants' beliefs and behaviors. Grounded theory method includes the use of an emergent design, theoretical sampling, axial and open coding, saturation, and concurrent data collection and analysis. Our method differed from this model to the extent that we used purposive rather than theoretical sampling. Purposive sampling involves the deliberate sampling for heterogeneity (Blankertz, 1998) on factors designated as important to the concepts being studied (e.g., gender, treatment status), whereas theoretical sampling seeks a sample that presents heterogeneity of concepts.

In addition, because we could find no qualitative research addressing this topic, we felt we should begin by conducting a preliminary focus group with adolescents recruited from the community. The focus group allowed us to gather information from teens who might otherwise have been reluctant to talk about their experiences

(Kitzinger, 1995). Furthermore, it was useful in gathering basic data on teens' ideas about health care and why and how they think what they do (Kitzinger, 1995). It also allowed us to establish preliminary questions and areas for investigation. After this preliminary information was gathered, we then began our investigation of teenagers who had been diagnosed with unipolar depression by their health maintenance organization primary care physician.

Participants and Procedure

We invited teens from a local high school to take part in the focus group portion of the study. The urban high school is heterogeneous, reflecting the range of socioeconomic and ethnic groups found in the Portland, Oregon–Vancouver, Washington, metropolitan areas. Focus group interview participants were 5 female and 2 male 15-year-old high school sophomores. These teens participated in a 90-minute after-school focus group interview ($n = 7$) conducted by the first author and a research assistant. Although diagnosis and treatment history were not assessed directly, three focus group participants disclosed that they had received psychotherapy or antidepressant medication at some time.

Although we would have preferred to use pure grounded theory methods of theoretical sampling for our individual interviews, logistical constraints made this impossible (e.g., we were unable to obtain specific information about teenagers' viewpoints without enrolling them in the study). We instead purposively sampled to obtain the maximum variability. This deliberate sampling for heterogeneity (Blankertz, 1998) provided a range of viewpoints from teens, who varied on characteristics that our preliminary focus group demonstrated to be salient to understanding the topic (i.e., age 14 to 19 years, gender, presence of depression diagnosis, and prior treatment). To the extent possible, we were, "maximizing opportunities for comparing concepts along their properties" (Strauss & Corbin, 1998, p. 202).

Interviewed teens ($n = 15$) were recruited from Kaiser Permanente's Northwest Region (KPNW), a nonprofit group model health maintenance organization serving northwest Oregon and southwest Washington. With the permission of their primary care providers, we contacted teens with depression diagnoses by letter and phone to invite them to participate.

Individual interview participants were 8 female and 7 male teenagers aged 14 to 19 years (mean = 16.3; $SD = 1.5$). Thirteen teenagers were White (non-Hispanic), and two were of Hispanic origin. Some participants were in treatment (antidepressant medication and/or psychotherapy), but most reported no longer engaging in medical treatment. Two participants were morbidly obese, and 3 reported severe medical issues, such as fibromyalgia or a seizure disorder. Treated and untreated teens from the health plan participated in a single 90-minute in-person ($n = 13$) or phone ($n = 2$) interview by the first author or a graduate research assistant.

We obtained institutional review board approval and informed consent, the latter from both the teen and his or her parent. Teens were informed of the confidentiality of their statements and assured that reports from their interviews would not contain identifying information. Furthermore, parents and teens were advised that any indication of harm to self or other (e.g., child abuse or suicidal ideation) might be reportable to ensure the teen's or others' safety. All teen participants received gift certificates and snacks for their participation.

Interviews and Analysis

We used in-depth individual and focus group interviews to learn about participants' experiences with depression and their attitudes toward obtaining treatment for depression. Interview guides[1] included questions about (a) participants' understanding of why they were depressed, (b) their process of examining their feelings and determining whether they needed professional help, (c) the process of obtaining professional treatment (if applicable), and (d) how they made sense of depression. We changed the wording of the interview guides slightly to make them appropriate to group versus individual format and treated versus untreated status.

In using grounded theory for the individual interviews (Strauss & Corbin, 1998), this portion of the study did not begin with explicit hypotheses to be tested. Instead, individuals were asked broad questions about their experiences, starting with the question, What is depression like for you? We also asked about what led to them seeking medical care for depression and what that process of meeting with their provider and obtaining treatment was like. Based on the results of earlier interviews and identification of issues that teens reported, we modified questions for later interviews and added questions that were more specific (e.g., how the diagnosis changed how they viewed themselves). We continued modifying questions and interviewing teenagers until we determined we were not obtaining any new information on the topic and it was saturated.

Interviews were tape-recorded, and field notes documented additional information, such as emotional content and nonverbal communication. Tapes of interviews and field notes were transcribed verbatim, and both were included in analyses. We analyzed interview and field note text using the Atlas.ti 4.2 software system, which aids coding, organization, and retrieval of text for qualitative analysis.

We developed and refined our themes through an iterative process. We examined the data and the generated open codes to form hypotheses, which were then recompared to the data and codes. This analysis led to modification and focus of interview questions and further analysis. During each stage of the analysis, we recorded thoughts, ideas, and hypotheses about the process. This constant comparative analysis helped further refine the themes. Open codes detailed primary concepts, whereas axial codes related categories to each other.

We took several steps to increase methodological rigor: (a) Multiple researchers participated in data collection and analysis to ensure multiple viewpoints and discussion of perceptions of data, (b) we sought consensus on coder agreement to ensure more accurate coding, (c) we considered rival explanations while analyzing data to facilitate trimming and validating the theoretical scheme, and (d) we compared researcher and theoretical findings to validate our findings (Boyatzis, 1998).

RESULTS

We developed a theoretical scheme based on teens' descriptions of their experiences as moving in a chronological order from (a) a growth of distress to (b) being in a funk, during or after which they (c) considered whether they were depressed. Those who received a diagnosis of depression then (d) considered their feelings and behavioral choices and (e) tried to make sense of their depression. Teens' responses to a diagnosis were of three types: Identity Infusers accepted the diagnosis as an

immutable part of their personality, Labelers used the diagnosis as a label helpful to their attempts to recover, and Medicalizers assumed a "patient" role and a medical view of depression.

Growth of Distress

Many teens reported remembering the time before they became depressed and indicated a wish to return to that time. Most discussed a portion of their childhood in which they experienced the absence of responsibility, future orientation, and stressful experiences. Remembering a utopian version of the time before depression appeared to reinforce teens' views that their depression was caused by current stressful situations. Furthermore, it led to both optimism and pessimism: Some envisioned a potential end to their distress once these current stressors were over, but most saw only increasing stress and responsibility with high school completion and the beginning of full-time work or college. This teenage girl struggled with depression, homelessness, and substance abuse:

> I miss the little girl I was at times. . . . I remember running in the streets barefooted in the summertime with all the neighborhood kids playing games every day . . . those are probably my happiest times, out having fun and being a kid. I grew up too quickly and missed that whole childhood thing and I want to go back.

Teens were able to describe the growth of their distress from imperceptible to incapacitating. They recounted the process as slow, taking months or even several years. For many, a significant event preceded their distress and was specifically identified as starting this growth of distress. Specific triggering events included parental divorce or separation, a parent experiencing cancer treatment, child abuse, or the death of a relative or friend. Several teens also had medical issues, including a teen who had experienced multiple surgeries for an infection, another who had engaged in a year-long process to diagnose a seizure disorder accurately, and two teens who were morbidly obese. Teens viewed these difficult stresses as directly related to their experience of depression and said such stressors exacerbated the normal difficulties of adolescence. One 19-year-old woman worked and went to college after moving into an apartment in the same city where she graduated from high school. She described the transition to adulthood as difficult, in part because of additional responsibilities and decreased social support from friends.

> I just hated life in general. I wanted to be back in high school, I wanted to be back home. . . . I'm transitioning from the mentality of a kid to an adult, so it's harder to make that transition when that cloud always seems to be over you.

Some interviewees identified no specific incident but, rather, an accumulation of stress over time that eventually eroded their ability to cope. This 17-year-old girl indicated a struggle with daily roles and responsibilities:

> *Moderator:* What causes depression for you?
> *Participant:* Probably the amount of stress I have in my life and just the pressure I have from my parents, my school, a lot of my outside environment. I don't get enough

> sleep. Usually it's just a string that starts out with something small and I'll hold it inside and then I'll just reach rock bottom where it will just come out.

This 16-year-old girl described a difference between sadness and depression.

> *Moderator:* Where do you think your depression comes from?
> *Participant:* From being unhappy with myself and with other people. . . . When I'm sad, I'm sad about certain things, but when I'm depressed I'm upset about myself.

During the growth of distress period, teens frequently attempted to normalize their symptoms.[2] They looked to peers for guidance and found that many other teens were feeling similarly. Checking in with others helped them to feel normal, and they often concluded that no actions needed to be taken. Despite this normalizing, they indicated, paradoxically, feelings of frustration with messages they perceived as being supportive of denying their depression. Such incidents included being told that they are experiencing the "time of their lives," which denied their adolescent angst, and media messages that reinforced that everyone should be happy all the time. Teens reported feeling distressed not just because they were not happy but also because they felt that they were supposed to be happy.

Being in a Funk

Teens were very clear that their experiences of being depressed were distressing and disturbing. They used phrases like "being in a fog," "having a cloud over" them, "dragging" along, and "feeling a weight" on them. Although some specific symptoms differed, teens described being in a funk in a consistent manner that included low energy, a desire to be alone, and a pessimistic outlook. A number of teens used remarkably similar language to describe their depression:

> It's just horrible. You're totally out of everything. You don't want to do anything. (17-year-old boy)

> There would be days that I just couldn't get out of bed. I didn't want to face people, I didn't want to look at anybody, I just wanted to stay there and I guess just sulk by myself, and I just didn't have any energy. (19-year-old woman)

> I felt pretty much helpless, lost at times, sad. I just want to shut off the world. I try to be alone. (15-year-old boy)

Others included aspects of mistrusting their own perceptions. Some managed metacognitions, telling themselves that their thinking was flawed, but were still unable to correct that thinking. For example, a 19-year-old said,

> The cloud always seemed to be over, there never seemed to be a sunny day. It could be 102 degrees out but to me it was the rainiest Washington day you ever had.

An 18-year-old described her experience this way:

> There's a little fog, this chain-mail wall where I can see out and I can see what's going on but I can't affect it.

The symptoms of distress were described as varying in severity over time. When symptoms were absent or comparatively mild, teens described themselves as feeling "okay." Teens who had an exacerbation of depressive symptoms, including low energy and isolation, described this as "being in a funk." Those who struggled with anxiety also experienced periods of heightened sensitivity during which they were particularly emotional. For example, this 17-year-old boy said,

> Sometimes I just get in these moods. I don't know what it is but I just don't want to deal with anything and then the slightest little thing I can either start crying or yelling. I call them my "freak outs."

Considering Whether They Are Depressed

Throughout the process of becoming more distressed, teens reflected on the difference between the time before they became depressed and what it was like to be in a funk. For many, this difference was great and created significant dissonance. In addition, if they were attempting to normalize their experiences by comparing them to those of other teens, this strategy eventually ceased to be effective, either because symptoms could no longer be characterized as "normal" (e.g., suicidal thoughts) or because the duration of the funks became too long to be easily dismissed. Teens eventually began to consider depression as a possible explanation for their experience and then took action to help them decide if they were actually depressed by talking to friends or family members who had been depressed or who had visited a medical or mental health professional. Despite the increasing availability of health information on the Internet and in libraries, very few teens reported using these resources for information.

Receiving the Diagnosis

Many teens in this sample had been to a health care provider for evaluation of their depressive symptoms. Teens reported different reactions to receiving a depression diagnosis. These reactions can be characterized as representing three types: Labelers, Medicalizers, and Identity Infusers. Table 1 contains summary information about these types and the number of individually interviewed participants who corresponded to each type. Although most could be categorized into one of the types, two teens appeared to fit both Labeler and Medicalizer categories.

Labelers. Labelers reported hearing the diagnosis with relief. They saw it as confirmation that their distress had a name and that they were not the only person ever to experience these symptoms. The diagnosis provided a label that was helpful in categorizing their symptoms and in giving them new ways to make sense of their distress. These teens tended to see depression as a temporary situation and to be interested in getting information about interventions to reduce symptoms. They expressed a relatively high sense of self-efficacy and tended to try multiple techniques, including self-help interventions, in their efforts to seek symptom reduction.

TABLE 1: Responses to Diagnosis of Depression and Related Themes

	Labelers (n = 6)	*Medicalizers (n = 6)*	*Identity Infusers (n = 3)*
Response to diagnosis	Relief	Concern, distress	Confirmation
View of diagnosis	Helpful label	Possession	Personality characteristic
View of etiology	Situational	Disease	Organic
View of time in depression	Temporary	Long term, chronic	Permanent
Self-efficacy	High	Medium	Low
Help seeking	Curious to find explanation	Seek relief of distress	Minimal help seeking
View of involvement of health professionals	Provides label	Reliance on medical professionals	Confirms self-image
View of medication	Generally refuse	Try and reject	Accept passively
Participation in treatment	Sometimes reject treatment	Active	Passive
View as learning experience	Yes	No	Sometimes
Prognosis	Good	Medium	Poor

NOTE: Two teens had characteristics of both Labelers and Medicalizers and were each counted as 0.5 per category. Teens included in this table were interviewed individually; focus group participants were not included in the table.

Medicalizers. For Medicalizers, hearing that a health care professional had diagnosed them with depression confirmed that they had a mental illness that required medical treatment. A 14-year-old boy told us,

> It was a little bit of a shock [when my physician diagnosed me with depression] because I just figured I was just being sad like any other kid but I didn't know it was that bad that I had depression and all that stuff and I needed to go on medication.

This teen accepted the physician's explanation for his feelings despite his contention earlier in the interview that he viewed his depression as caused by teasing at school and living in a difficult family situation. These teens felt an aspect of ownership of their diagnosis, as if their physician handed them a tangible object they had to carry around until the medication made it go away. These teens tended to be distressed or bothered by the diagnosis and to rely primarily on their physician for information and options. Curiously, medicalizing teens were not necessarily treatment adherent. They viewed depression as interfering with their lives to some extent but not necessarily as something that required aggressive treatment.

Identity Infusers. The Identity Infusers saw a depression diagnosis as confirming a part of their identity. They saw "being depressed" as a personality characteristic and, correspondingly, tended to be more pessimistic about the likelihood of recovery. This group tended to report more severe depressive symptoms, and its members were more likely to report feeling depressed for a longer time than the others. For example, this 15-year-old boy's comment exemplifies the extent of this experience:

> Just because I had been that way for so long that I didn't think it could be depression.

Receiving a diagnosis was not particularly stressful for these teens, perhaps because they tended to have more tenuous connections with their health care providers. Teens in this group did not change their behavior significantly (i.e., try

different symptom relief techniques) and tended to view interventions with suspicion and hopelessness.

Making Sense of Depression

Once teenagers were told by a health care provider that they were depressed, they then decided whether to (a) agree with that label, (b) integrate the information of the diagnosis into their self-image, (c) participate in the treatment recommended by their physician, (d) participate in other forms of interventions, or (e) choose no intervention. Labelers accepted the diagnosis as a useful way of describing their constellation of feelings. The information was integrated as a temporary life challenge but not as part of their identity. They varied on whether they participated in treatment, with some choosing to "try out" the physician's recommendations and others choosing to attempt to handle it on their own. They tended to be treatment compliant, but for short periods of time. They took responsibility for their experiences and actively chose how to respond to them.

Medicalizers agreed that the diagnosis explained their experiences and saw depression as something that belonged to them. They tended to view their health care provider as responsible for "fixing" the problem and did not take responsibility for its remedy. They tended to become frustrated with providers who were not as available as they would like and to accept treatment recommendations in the office but not follow through with taking medication or attending counseling appointments. This group tended to be the most vocal in discussing how providers were not helpful to them. This 16-year-old boy had endured multiple tests for a medical problem and was frustrated with the time required and uncertainty of treatment for depression.

> I was thinking that somebody has got to know the solution, somebody has got to know what I'm going through or how to deal with this, and then after so many times of not coming up with an answer the first time, because I don't have patience, I just want things to be over with. . . . I want them to happen in a day.

Identity Infusers tended to agree with the diagnosis and immediately integrated it into their self-image. Members of this group, which tended to have the most severe depression, would say statements like, "I think I was always depressed and just didn't know it," and have negative views of ever becoming nondepressed. This group tended to be medication compliant but did not get better. For some of these teens, however, depression appeared to have become a habit, as this 15-year-old boy described:

> [Depression can be] addicting, conditioning, 'cause if you're depressed for a long time you might feel happy one day but then it's like you go back to being depressed again and it feels like something's wrong if you're *not* having that sort of feeling.

Some Labelers and Identity Infusers considered the experience of depression as a learning experience. They viewed their symptoms as normal reactions to an external stressor or as indications they needed to understand or learn something. Although teens such as this 17-year-old boy reported a longer symptomatic period, they tended to report being the most at peace with where they were in life.

> I don't know if kids who are depressed necessarily need to be freed from it immediately. I think I'm better for some of the things I have experienced. [*Better?*] Just I guess I'm more pessimistic, and pessimistic people get nothing but pleasant surprises. It's helped me view other people differently.

For these teens, symptom management and self-exploration become an iterative process, and input from medical providers becomes only a portion of the information they use to make their decisions.

DISCUSSION

Consistent with work on adults (Karp, 1994; Schreiber, 1998), we found that teens' subjective experiences of depression and their conceptualization of depression affected their decisions and attitudes about seeking medical treatment and following treatment recommendations. Teens' responses to depression diagnosis are multifaceted and related to both their willingness to engage in health care services and their recovery from depression: Teens who tended to view a diagnosis as a helpful label were less likely to report wanting to engage in health care services but more likely to report recovery.

Our results suggest that to the extent that helping professionals and family members can assist teens in the process of understanding their depression, teens might be likely to feel better. The growth of distress and being in a funk stages offer a number of opportunities for family members and health care professionals to intervene. Those who know teens best might be able to identify recent behavior that seems different from previous behavior or indicates problems. Discussing this kind of information with teens might help them move toward considering whether they are depressed. When considering their possible depression, teens in this sample reported relying heavily on feedback from parents and peers. This suggests that providing psychoeducational information about depression to both parents and teens could help teens make their determinations more quickly and accurately.

Medical providers and parents might also want to consider how individual teens respond to a diagnosis of depression: whether they find it a useful label, medicalize the situation, or incorporate the diagnosis into part of their identity. To the extent that parents and clinicians can identify these reactions, this understanding might help them help teens. For example, parents and health care providers can challenge the reliance of Medicalizers on clinicians, encouraging them to engage in self-help activities, thereby promoting the teens' autonomy. Providers can also employ empowering techniques (e.g., Deegan, 2000) to assist teens with services that are sensitive to their needs. Although the categories of Labeling, Medicalizing, and Identity Infusing, delineated in Table 1, are provisional and require further validation, they might be useful guides in understanding teens' reactions to receiving a diagnosis of depression.

Our findings also challenge general conceptualizations of depression. Diagnosis is currently used to label behavior, to help guide treatment protocols, and to obtain insurance reimbursement. Although some teens do find it useful to label or name their particular symptoms, our data indicate that for many, such labeling might be harmful, transforming attributions about symptoms into an illness identity that impedes recovery. This is consistent with sociological work on the negative

effects of labeling (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). For example, it might be particularly difficult for Identity Infusers to recover from a condition they view as a stable part of their identity. Other teens might view the experience of being depressed as an opportunity to learn about themselves and others, in the end seeing it as positive.

Although the mechanisms of information transmission are not clear, information and attitudes from providers might influence teens' perceptions of depression, treatment efficacy, and self-image. Provider-patient communication has important effects on both short- and long-term health, including symptom experience, compliance with recommended treatment, and speed of recovery (Roter & Hall, 1992; Wisdom et al., 2003). It might be that matching clinicians' communications to teen responses (e.g., Labeler, Medicalizer, or Identity Infuser) could improve teens' outcomes.

Future research should elucidate how patient-provider communication involving teenagers with symptoms of depression can affect teens' attitudes and depression outcomes. Qualitative research in this area would benefit from integration of quantitative measures of satisfaction with medical treatment, adherence to recommended treatment, and longitudinal follow-up of depressive symptoms. The experiences of teens who have depressive symptoms but who have not sought medical care should also be addressed. Such teens have not had the experience of a medical professional offering a diagnosis to explain their symptoms and will likely have a different illness-wellness trajectory. Finally, results suggest the need for replication of this study in other ethnic and socioeconomic groups. If additional research supports the presence of similar findings in a variety of groups, the possibility exists to define further specific aspects of teen experience and perception, thus allowing for the development of more appropriately tailored interventions.

CONCLUSION

We have described the experiences of teens with depression symptoms to provide information and explanation of teens' experiences to health care providers. Health care providers might be able to help teens by understanding that their views of depression are likely different from those of health care professionals. Providers might be able to tailor responses and interventions to teens, possibly increasing the teens' likelihood of participating in treatment and recovering from depression. Furthermore, by using empowering techniques (e.g., Deegan, 2000), providers can support aspects typical of teens' experiences as well as a diversity of recovery trajectories.

NOTES

1. Copies of the interview guide can be obtained from the first author at wisdomj@ohsu.edu.

2. In this article, the word *symptoms* is used to describe the feelings, thoughts, and behaviors that teens described as troublesome to them and that are typically associated with depressive disorders. Teens did not generally use this word in their speech, but it is used here to facilitate communication.

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