










## Social isolation as a core feature of adolescent depression: a qualitative study in Porto Alegre, Brazil

Anna Viduani , Silvia Benetti , Thaís Martini , Claudia Buchweitz , Katherine Ottman ,  
Syed Shabab Wahid , Helen L. Fisher , Valeria Mondelli , Brandon A. Kohrt  and Christian Kielling<sup>a,f</sup>

<sup>a</sup>Department of Psychiatry, Universidade Federal do Rio Grande do Sul, Porto Alegre, RS, Brazil; <sup>b</sup>Division of Global Mental Health, George Washington University, Washington, D. C, USA; <sup>c</sup>Social, Genetic & Developmental Psychiatry Centre, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK; <sup>d</sup>ESRC Centre for Society and Mental Health, King's College London, London, UK; <sup>e</sup>King's College London, Department of Psychological Medicine, King's College London, Institute of Psychiatry, Psychology & Neuroscience, London, UK; <sup>f</sup>Child & Adolescent Psychiatry Division, Hospital de Clínicas de Porto Alegre, Porto Alegre, RS, Brazil

### ABSTRACT

**Purpose:** The goal of this study was to explore the perspectives of different stakeholders regarding the experiences of adolescent depression in Porto Alegre, Brazil.

**Methods:** We conducted 54 key-informant interviews with adolescents, parents, social workers, health workers, educators, and policy makers and two focus group discussions with 5 adolescents and 6 parents. Data were analysed using a framework approach and guided by the adolescents' personal narratives, with adult stakeholders' views supplementing these perspectives.

**Results:** Four main themes emerged, creating a relational model of adolescent depression that highlights isolation as a central component of the experience. In relation to the self, the experience of depression led to a feeling of detachment from others resulting from the sensation that usual interactions did not have the same meaning as before. This disruption of interactions is perceived as self-isolation and is described in relation to coping mechanisms.

**Conclusion:** These findings shed light on important aspects of the identification and management of adolescent depression in Brazil. Since social interaction was a core component of the descriptions and experiences of depression, we speculate that promising interventions are those that could enhance the promotion of a supportive environment and interpersonal relationships.

### ARTICLE HISTORY

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### KEYWORDS

Depression; social isolation; qualitative research; adolescence; Brazil

## 1. Introduction

Understanding the experience of depression in adolescence—a crucial developmental period—is essential to address this burdensome psychiatric disorder affecting a large number of youth worldwide (Thapar et al., 2012). A large proportion of first episodes of depression occur during adolescence (Kessler et al., 2007) in parallel with intense processes of emotional maturation that are shaped by social context (Osher et al., 2020). Context, including stressors, availability of social resources, and cultural interpretations, is central to when, by whom, and how depression is experienced during adolescence.

Studies have shown that context manifests itself in interpersonal and community processes (Osher et al., 2020). Therefore, the experience of depression can be assumed to be highly specific to the context in which it is produced. Likewise, the current conceptualization of adolescent depression as presenting core symptoms similar to those observed in adults may mean that important features of depression that are unique to adolescence are missed and need to be further

explored (Midgley et al., 2015; Orchard et al., 2017). Therefore, investigations oriented to expand our knowledge about the way adolescents experience and/or perceive this mental health disorder and identify which domains are relevant to clinical practice from the perspective of the adolescent who experiences depression, of parents, and other stakeholders (Chevance et al., 2020) may yield important contributions to improve diagnostic practices and interventions.

Qualitative approaches that integrate developmental aspects, contextual factors, and stakeholders' perceptions about depression (Farmer, 2002) have been advantageously used to address this gap in the literature. Most such studies, however, have been conducted in Western, Educated, Industrialized, Rich and Democratic (WEIRD) societies (Blakemore, 2019; Henrich et al., 2010). Given the importance of context to both the development and the onset of depression in adolescence, understanding how adolescent depression is experienced and perceived in other cultural environments is therefore necessary and desirable.

Similarly to what is the case in many other Western cultures, in Brazil most individuals are encouraged to develop self-reliance (Chen et al., 2004). Nevertheless, they also hold group-oriented attitudes towards family members and peers, reflecting important non-WEIRD influences on cultural values (Van Horn & Marques, 2000). Therefore, the present study was designed to qualitatively explore the experience and perceptions of adolescent depression in the city of Porto Alegre, Brazil, with the aim of contributing to the modest body of literature focusing on the experience of adolescent depression (Dundon, 2006) and expanding this to a non-WEIRD context.

## 2. Materials and methods

### 2.1. Study setting

Porto Alegre, where the present study was performed, is the southernmost state capital of Brazil—the most populous country in Latin America, with an estimated 212 million inhabitants of whom 51 million (close to 25%) are between 10 and 24 years of age (PAHO, 2017). A similar population distribution is found in the city of Porto Alegre, with 325,000/1.5 million population aged 10 to 24 years (IBGE, *s.d.*).

Despite many challenges, public education and health care are constitutional rights in Brazil. Thus, public state schools account for about 78% of all schools in the country (Ministério da Educação, 2018), and while almost one third of adolescents either struggle to complete or have dropped out of school (IBGE, 2018), literacy and access to school have increased over the years, with school enrolment reaching up to 88% of adolescents. In terms of health care, the universal Unified Health System (SUS) also faces many implementation barriers (Castro et al., 2019); importantly, access of children and adolescents to mental health services via the SUS is complicated by the scarcity of services dedicated this age group (Kieling & Belfer, 2012; Paula et al., 2014), and private health insurance, while available, does not cover mental health services. The same challenges are faced by Porto Alegre, despite its relatively high Human Development Index (0.805) (PNUD, Ipea, & FJP, 2013)—a statistic combining indices of longevity, access to education and income *per capita*, with higher scores indicating to a good human development in general—and the fact that it compares favourably to other cities in the country (Brazil's overall HDI in 2013 was 0.753 (PNUD, 2013)).

### 2.2. Study design and sampling

The present study was designed following the Framework Method (Gale et al., 2013) to explore the experience of adolescent depression at the individual

level through key informant interviews (KII) and focus group discussions (FGD). This study was developed as part of the Identifying Depression Early in Adolescence (IDEA) consortium (Kieling et al., 2019), which includes a qualitative component, a protocol described in detail elsewhere (Wahid et al., 2020).

Sample size was determined *a priori* based on studies suggesting that approximately 6–12 interviews are sufficient to reach code saturation in a homogeneous group (Guest et al., 2006). Based on that assumption, we conducted 54 key-informant interviews with participants including health workers in the public and private sectors ( $n = 12$ , 11 females), educators ( $n = 12$ , 10 females), social workers ( $n = 12$ , 11 females), policymakers ( $n = 6$ , 2 females), parents of adolescents with depression ( $n = 6$ , 4 females), and adolescents with lived experience of depression ( $n = 6$ , 4 females).

Two FGDs were also conducted, one with adolescents ( $n = 5$ , two females—out of seven who had been invited; two adolescents were unable to attend the discussion, one due to a last-minute family emergency and another due to schedule conflicts) and another with parents ( $n = 6$ , 5 females). Adolescents were between 14 and 17 years of age (mean age = 15.3 years) and all attended public state schools in the city of Porto Alegre. Eight adolescents reported lived experience of depression (all adolescents participating in the KIIs and two from the FGD). All the adolescents included (11) had a mental health-related history of service use—however, clinical diagnosis confirmation was not ascertained prior to their inclusion in the study.

Health care workers, educators, social workers, and policy makers were sampled by convenience, drawing from the researchers' professional network, and were chosen if they had previous experience working with adolescents. Most of those who agreed to participate had met the researchers and were familiar with their ongoing research. They were also asked to suggest other professionals in their network that could take part in the interviews. Parents and adolescents were recruited from a group involved in a research project on adolescent depression (Kieling et al., 2021).

### 2.3. Data collection

Development of the KII and FGD guides were informed by Engel's biopsychosocial risk factors approach (Engel, 1977), and Kleinman's explanatory model framework of mental illness (Kleinman, 1980). The guides were developed by the research team and reviewed by two senior researchers (CK and BK). Six pilot interviews were conducted and subsequently the guides were adjusted for cultural and contextual aspects.

The primary areas explored in both KII and FGDs were the experience of adolescence, the experience of

adolescent depression, and adolescent coping strategies in response to stressors and depression. We also queried respondents about which stakeholders would be best positioned to identify depression early in adolescence. Societal perspectives surrounding adolescence and adolescent depression were also explored.

### 2.3.1. Key-informant interviews

One-on-one semi-structured interviews were conducted in Brazilian Portuguese. In Portuguese, the term “depressão” was used to refer to “depression,” which represents both a commonly understood term in the general public as well as a clinical diagnostic term used by practitioners for clinical diagnoses of depression.

KIIs were conducted with health care workers, educators, social workers, and policy makers. They were interviewed at Hospital de Clínicas de Porto Alegre or other locations depending on convenience (e.g., private practices) by AV, SB, or TM. Four interviews were also carried out by a fourth researcher, LT, a female psychologist with a PhD and experience in mental health research. The duration of KIIs ranged from 40 to 90 minutes.

### 2.3.2. Focus group discussions

Both FGDs were conducted at Hospital de Clínicas de Porto Alegre simultaneously, but in separate rooms. The adolescent FGD was conducted by AV and TM, and the FGD with parents was conducted by SB and CB. All researchers involved with data collection are women with a background in mental health research (at the time of the study, AV was pursuing a master’s degree, and CB was pursuing a PhD, while TM and SB were postdoctoral research associates). All researchers were trained in qualitative methodology with a focus on data collection with adolescents and were supervised by two senior researchers, a child and adolescent psychiatrist with experience in research on adolescent depression (CK), and a psychiatrist and anthropologist with experience in global mental health research (BK). After KIIs and FGDs, all interviewers completed debriefing forms that were later used to inform coding. Analysis was guided by the researchers’ assumptions of depression as an experience that happens both at individual and at societal levels, following an ecological systems perspective that aims to understand reality from a broader perspective that includes person, process, and context. FGDs lasted 90 minutes. All were audio-recorded and later transcribed in Brazilian Portuguese. In preparing the manuscript for publication, the original quotes were translated into English. For original quotes in Brazilian Portuguese, see [Appendix A](#).

## 2.4. Data analysis

A deductive theory-informed codebook was initially created, which was later modified to include inductive codes and categories. The final codebook was used to code the full dataset using NVivo version 12 (Richards, 1999). Two researchers (AV and SB) coded the data in Portuguese. We considered an inter-rater reliability of 0.7 (Cohen’s Kappa) among the coders as an indication of reasonable agreement (McHugh, 2012). We used the constant comparison approach during coding—newly coded sections were compared to previously coded data to ensure the integrity of codes across the dataset (Glaser & Strauss, 1967). At this point, the debriefing forms were also taken into account, providing information about the context of the interview and the interviewers’ assumptions about the topic.

Inductive codes and themes were introduced as these were identified, until the data produced no new codes or themes, suggesting theoretical saturation (Strauss & Corbin, 1990). Afterwards, code queries were executed in NVivo and stratified by adolescents and other stakeholders, and code summaries were written to capture adolescent and stakeholder perspectives. Finally, we constructed framework indices with code summaries stratified by stakeholder type to allow comparison across diverse narratives. A pragmatist paradigm was undertaken, aligned with the view that reality is both constructed socially and based on one’s own experiences of the world (Onwuegbuzie et al., 2009). For the present study, we focused primarily on codes that were oriented to capture the experience of depression: Signs & Symptoms of Depression, Depression vs. Other Experiences, Impacts of Depression, and Coping Strategies. The complete framework used for analysis and stratified by respondents can be provided in [Appendix B](#). Lastly, a relational model was created by refining the codes and the generation of an overarching theory that connected the identified relationships across categories and themes. All stages of analysis and reporting were executed according to the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007) [[Appendix C](#)].

## 2.5. Ethics

Ethical approval was obtained from the Hospital de Clínicas de Porto Alegre Ethics Committee (CAAE: 03220818.0.0000.5327). All procedures performed in this study followed the ethical standards of the institution. All participants included in the study provided written assent/consent. To ensure the protection of confidentiality and full anonymization of the data, any identifiable details given by participants during their interviews were omitted in the interview transcripts.

Participants were also assigned codes to protect their identities.

### 3. Results

#### 3.1. Youth voice

When trying to understand the adolescent experience of depression, it is important to look at it from the perspective of both the adolescent and the adults that take part in their life. Our adolescent participants vehemently expressed their need to be heard:

“They think [parents and school workers] we don’t have problems. [...] I have problems and I have thoughts that are much more than what you think, because you [adults] have your own impressions and impose these impressions on us [adolescents]” (Adolescent 3, male, 15)

Therefore, data analysis was guided by the adolescents’ own narratives and experiences. These accounts guided our analysis and were taken as primary to orient theme generation and organization. However, stakeholders’ perspectives and perceptions were also considered as complementary accounts since we are interested in the context and social interactions adolescents were involved in. We chose to disclose these perspectives whenever they offered a contrasting perspective, enriching the understanding of the reactions from the environment and social actors in the adolescents’ lives. The present analysis, therefore, was guided by a subset of areas explored in both KII and FGDs that focused on the experience of adolescence, the experience of adolescent depression, and adolescent coping strategies in response to stressors and depression. This generated four main themes related to the experience of lived depression: (1) depression in relation to the self; (2) depression in relation to others; (3) isolation as the main characteristic of depression in adolescence, and (4) coping with depression.

#### 3.2. Theme 1—depression in relation to self

Adolescents interpreted their experience of depression around two main dimensions, emptiness [sentirse vazio] and sadness [tristeza]. Feeling depressed altered their perspective on aspects of life they had previously perceived as enjoyable, which were basically centred on relationships, like being with friends and family. This way, depression was often expressed in terms of emptiness that led to a sense of wanting to be alone [ficar sozinho]. All adolescents mentioned these overwhelming sensations as one of the core components of the experience of depression:

“I felt empty, like I didn’t want anything else. I didn’t want to do anything, I didn’t want to study or talk to anyone, I didn’t want to be friends with anybody.

I just wanted to be quiet, and be by myself.” (Adolescent 6, female, 15)

For most of the adolescents, these feelings were also accompanied by sadness, which was mentioned by eight of the 11 respondents. Both feelings seemed to be motivated by the loss of interest and ability to focus on activities that once were enjoyable:

“You feel empty, not happy anymore, with no desire to do things you liked before. I like to read, to watch TV shows, but sometimes I don’t feel like doing these things, I have no will. Then, if it is something recurrent, I see that there’s something wrong, I may be depressed.” (Adolescent 8, female, 15)

This loss of interest and will to live were mentioned in association with suicidal thoughts, another commonly described feature of depression in adolescents. The lack of perspective and search for quietness played an important role in the occurrence of these feelings, as described by Adolescent 6, a 15-year-old girl with depression:

“It’s hard not to mess things up. Doing bad stuff (...) like killing yourself. It’s a big, big challenge. I wanted to.” (Adolescent 6, female, 15)

#### 3.3. Theme 2—depression in relation to others

To adolescents, interpersonal relationships are at the core of many aspects of the experience of depression. This way, the relationships with others defined many aspects of the evoked accounts of depression.

##### 3.3.1. Subtheme: relation to parents and peers as explanatory models of depression

Adolescents placed interpersonal relationships problems at the core of the explanatory models for depression, especially concerning family and peer relationship issues. Adolescents mentioned that parents are very important to their emotional development, and that constant conflicts with parents jeopardize the quality of these relationships and make teens withdraw from spending time with their family. They also mentioned that when parents did not acknowledge their problems, they felt worse.

“They think that just being around is enough, and that we don’t need to talk about our problems. (...) They think that just because we don’t have bills to pay, we don’t have any problems.” (Adolescent 2, male, 16)

In relation to this, they also cite the importance of bullying by peers as another central cause of depression. Being bullied because of physical appearance or sexual orientation is a difficult experience mentioned by all adolescents as an important cause for depression:

“I don’t know if this is specific to Brazil, but bullying is one of the main causes. The person is already facing

a lot, and on top of that, suffers bullying. The adolescent wants to be part of a group, and when they face bullying, they feel threatened.” (Adolescent 1, female, 14)

### 3.3.2. Subtheme: most symptoms go unnoticed

Adolescents highlighted that most of the time the people around them did not notice their sadness, especially since their self-isolation made it harder for others to reach out to them. The lack of straightforward, sensitive communication with parents and teachers was also mentioned.

“When there is a problem – like when I had a school attendance problem, [...] not one teacher came to me and said, “hey, is there something happening, why are you missing school?” No. The only thing I heard was ‘oh, you’re going to fail, your attendance is low. Oh, you never come to class.’ That was the only thing I heard.” (Adolescent 7, female, 17)

Parents, in turn, expressed their concerns about the generational components of distinguishing depression from other experiences. They reported a lack of knowledge about the real scope of the adolescent’s feelings and expressions, or what feelings are typical of adolescence, and how the adolescents express and live their experiences.

*“What I’m thinking is that sadness ... What do you think depression is? What is sadness? What are your conceptions of sadness? Because I, as a mother, understand that being sad is looking down, being quiet ... And to him, it isn’t.” (Mother 8)*

Parents also observed that once they reached adolescence, their sons and daughters often started spending a lot of time in their rooms avoiding family moments and refusing to spend time together. It was, however, not clear to them to what extent these behaviours were related to adolescence or were indicative of suffering:

“I noticed that she was more closed, but I thought it was just a teenager thing, because of adolescence ... But, she is getting more closed, and she always had a good relationship with me. (...) And I noticed she was sad, she was not like that. She used to be talkative, happy, always ready to help everyone. I noticed she was down, quiet, in her own world.” (Mother 4)

### 3.3.3. Subtheme: impacts of depression

Depression had an important impact on the adolescent’s lives.

“It’s like a delay. It’s a delay that, liking it or not, is a moment you lose all the will to do stuff. (...) And it’s not because you want to, it’s just because you don’t know what to do. You don’t know how to deal with your friends, you don’t know how to deal with your studies ... You can’t develop because you’re going backwards ... ” (Adolescent 7, female, 17)

At an interpersonal level, they reported family and peer relationship issues, as well as impacts on school performance. Being isolated from others, they felt an increased inability to deal with problems or adverse situations:

“Everything’s hard, it seems like everything makes you sink deeper.” (Adolescent 4, female, 15)

For the other stakeholders, consequences extended from milder ones, like lower grades or poor academic performance, to more severe consequences, like school dropout, self-harm, and suicide ideation/attempt.

“There are some who don’t want to go [to school]. There are some that go but end up being isolated, there are those who find other ways to express themselves too. [...] And there are others who go crazy, freak out and ... Fail school again and again.” (Social Worker 5, female)

When asked about the impacts of depression, adults mentioned aggressiveness. According to them, anger often manifested in moments when the adolescent is dealing with peers in the school setting. They also mentioned irritable mood and weight gain. Another important consequence of being depressed was the stigma associated with a psychiatric diagnosis.

“[The impact of a crisis] is really strong. For example, we get many adolescents coming from the ER. The first impact is being considered as crazy and considering themselves crazy.” (Health Worker 4, female)

## 3.4. Theme 3—*isolation as the main characteristic of depression*

Isolation, defined by the adolescents as an active pursuit to shut others out and active exclusion from spaces of social relations, was the main characteristic of depression described by adolescents. It is interesting to note that isolation seems to be the link that ties depression in relation to the self and to others: the feelings of emptiness, sadness and loss of interest lead to this active withdrawal that, in turn, influences the relational aspects of adolescent depression. One adolescent—#6, a 15-year-old girl with a long history of mental health issues, provided a clear picture about this component of adolescent depression:

“I want to be alone.” The first time [first depressive episode], all I could think was that I wanted to be alone, wanted to be in my own corner. All I could think about ... I want to be alone.” (Adolescent 6, female, 15)

This isolation, however, was not a source of distress for most adolescents. They mentioned this active isolation as related to the lack of desire to do things they used to enjoy. This lack of interest in everyday situations and interactions led to adolescents reporting

avoidance behaviours, but also feelings of irritability and even suicidal ideation. She continued:

“I didn’t want anything at all: I didn’t want to do anything, I didn’t want to talk to anybody, I didn’t want to be friends with anybody anymore. (...) And you end up being mad too.” (Adolescent 6, female, 15)

Adolescent 8, a 15-year-old girl who participated in the FGD, also testified about this active avoidance. When talking about a friend who was diagnosed with depression, she said:

“I have invited her to go out several times, go to my house, or even go the movies ... But she always refused.” (Adolescent 8, female, 15)

The active avoidance of others and the negative feelings surrounding isolation then create a cycle the adolescents felt trapped in, as expressed by another adolescent, a 15-year-old boy:

“I don’t know how to explain, I felt ... trapped. Like there was something inside me I couldn’t get rid of. Like a weight on me. And I would get really upset, and keep thinking about it” (Adolescent 3, male, 15)

This cycle of isolation and avoidance is also expressed by the health professionals we interviewed:

“They don’t want to hang out with their friends, and if they do, they don’t see it as something nice, they just complain about what happened in the outing. Nothing is good, and it’s all the time - they complain, they don’t feel adequate. This is often linked to avoidance, which spirals into a bad cycle, and the adolescent doesn’t even try to go out anymore.” (Health Worker 3, female)

Interestingly, they stated that this isolation is caused by beliefs that adolescents with depression have about the quality of the relationships and about themselves. The feeling of not being adequate, or even the feelings that they will not be understood by others has several impacts on the maintenance of social relationships:

“I think that because of depression, a person isolates themselves and thinks that there are never any solutions for their problems, and that no other person is in the same situation, that people can’t understand their suffering.” (Adolescent 1, female, 14)

By cutting off their peers and parents, adolescents seemed to find solace from the feelings that arose from depression. Only one adolescent linked “being alone” with feelings of loneliness:

“Feeling very sad and very lonely. Having no will to live. This ... I think these are the signs you are depressed.” (Adolescent 4, female, 15)

The other stakeholders—especially parents and teachers—also described the role of social isolation: to them, depression makes adolescents more susceptible

to disengage from social relationships. In the school environment, teachers mentioned that adolescents did not take part in academic activities, while, at home, parents mentioned that adolescents stayed in their bedrooms all day. They also mention constant fights with friends and refusals to go out as impacts of depression.

“My daughter just stays in her room. We don’t have direct sunlight in our apartment, just in the morning for 20 minutes, it’s sad. And I tell her we have to go out, even if it’s just to the supermarket, but she is always lying down, using her phone. I worry about her a lot.” (Mother 2)

### 3.5. Theme 4—coping with depression

When they felt depressed, adolescents described engaging in coping strategies focused on emotional regulation such as exercising, writing, and having positive thoughts about difficult situations.

“Lately, when I feel bad, I try to look more on the positive side. Then I see that it’s not just that, that there are good things (...) I talk to my cousin, too, like ... It’s good to let off steam.” (Adolescent 5, female, 14)

Interpersonal coping strategies, though, were frequently mentioned as the most important alternative to help deal with depressive feelings. Discussing problems with family members, like mothers, grandmothers, and cousins were an important source of support. These interactions seemed to be focused on the distraction from bad feelings and less on problem-solving. In relation to isolation, however, interpersonal coping strategies were often seen as part of a contradiction between shutting out others and avoiding relations and the need for relieving negative feelings, and recognizing the need for social support and the possibility of accessing it:

“There are moments when it is unbearable to be around people, but there are moments when I don’t want them to go away from me.” (Adolescent 2, male, 16)

Adolescents also mentioned seeking support from teachers and friends. Some adolescents opted to engage in social networking, and others mentioned seeking professional help.

“At the psychologist too, I took the initiative to go to the psychologist, because I felt the need to share my problems with a professional.” (Adolescent 8, female, 16)

However, they also mentioned negative coping strategies. Some participants mentioned the use of cigarettes, drinking alcohol and using drugs. These strategies, though, were less cited by adolescents. They often preferred expressing these negative coping strategies by using others as example

"A lot of people self-harm. Looking for some sort of relief. There are also people ... Even artists, that escaped into drugs, they could not face being in pain anymore and escaped into drugs." (Adolescent 3, male, 15)

This same distinction between positive and negative coping strategies was described by other stakeholders. Positive strategies were related to the adolescent's level of connectedness with friends, family, and other important adults in whom the adolescents could trust in, while negative strategies cited were the use of cigarettes, drinking alcohol, and using drugs. Stakeholders mentioned that severely depressed adolescents often engaged in self-cutting behaviours and suicide attempts as a way of feeling better.

Interestingly, girls were seen as better in interpersonal coping skills—they sought help more often and supported each other more. Conversely, boys were described as being more individualistic, and therefore their coping skills more often included isolating themselves.

"Look, the girls they are ... They try to unite so they can help each other [...] They are more united. They comfort one another sometimes. There's a positive side to it. Sometimes one girl says to another "no, you can go to my home, my mom can help you". Girls unite themselves more, while boys are individualistic." (Educator 5, female)

Adolescence is a key period to understand this aspect of coping. The existence of a group of friends is a major feature that influences their ability to cope with situations. They seem to look for groups where they can feel safe, included and understood. Thus, almost all the strategies mentioned by the stakeholders include social interaction.

However, group strategies were described as a good strategy only when the main intention of the group was to help each other, allowing for an idea of purpose. The negative side of the group was the influence on the use of drugs or on engaging in self-harm.

"Positive [coping strategy] is talking, when they manage to talk about their feelings in groups, (...) but mostly in the family - and having someone that listens in the family. I think this is a very good coping strategy." (Father 1)

### 3.6. Relational model of adolescent depression

Based on the interviews and the generated themes, we proposed a relational model of adolescent depression informed by Brazilian adolescents (Figure 1). By combining the themes and its relations, we were able to emphasize isolation as a core component of the perceived experience of depression. Isolation is here described as an active exclusion from spaces of social relations, and this experience seems to connect depression both in relation to the self and in relation to others. This means that the model highlights the social aspects of adolescent depression as core components of the experience. Also, we highlight that Brazilian adolescents often employed coping strategies focused on emotional regulation as a way to mitigate the experience of isolation.

## 4. Discussion

This exploratory study provides some insights into how adolescents from a Brazilian city experience and perceived depression. Four overlapping themes emerged: (1) Depression in Relation to Self; (2)

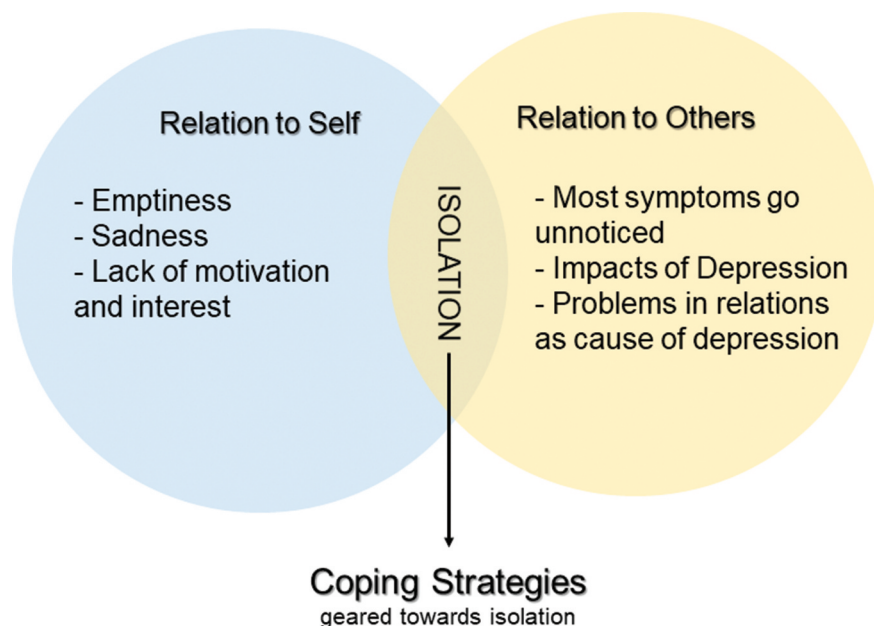


Figure 1. Relational model of adolescent depression.

Depression in Relation to Others; (3) Isolation as the Main Characteristic of Depression in Adolescence, and (4) Coping with Depression. Following this, a relational model for adolescent depression was proposed, having isolation as a core component of the experience of adolescent depression.

When describing their personal experience with depression, sadness and feelings of emptiness were the main features described by the adolescents. These findings resonate with the narratives of adolescents from several previous studies on the topic (Farmer, 2002; Midgley et al., 2015; Weitkamp et al., 2016). Even though sadness and emptiness reflect the core symptoms of the diagnosis of depression, the perspective from which depression was narrated emphasized the importance of interpersonal relationships. This focus of the narratives and perceptions, and the words used by adolescents when doing so, highlights that the clinical jargon used to refer to symptoms does not necessarily find its way into the adolescents' discourse—e.g., the use of “loss of interest and/or enjoyability of activities” by adolescents instead of referring to the technical term “anhedonia”. Across all themes, relational aspects were the overarching narrative emphasized by adolescents, being this the prism through which they interpreted their depression-related symptoms and experiences. The proposed model, then, highlights isolation—an active withdrawal from others—as a core component of the experience of adolescent depression in Brazil. Qualitative research among adolescents with depression in other LMICs has also highlighted the domain of interpersonal relationships (Rose-Clarke et al., 2021).

We could speculate that, in relation to the self, the experience of depression led to a feeling of detachment from others, described as resulting from the sensation that usual interactions did not have the same meaning as before. The consequent active avoidance of family and friends was the option which, in turn, placed adolescents in an isolated position. This sense of isolation—that could be understood as a means of “self-isolation” (Midgley et al., 2015) was not seen by adolescents as a symptom, but rather as a way of resolving or avoiding the problems that arose from the experience of disrupted relationships caused by depression.

This dynamic, therefore, places isolation at the centre stage of the adolescent's relation to the self and to others, and was described as a trap which kept them in a cycle that was hard to break, since approaching someone to talk about how they felt was a major challenge. This withdrawal extended to family and friends, and was interpreted by these stakeholders as a conscious avoidance on the part of the adolescent. Adolescents, in turn, did not seem conscious that this distance was also self-imposed, and described their

feelings in a more passive way, with strong ties to the feelings of imprisonment—they felt trapped in this self-isolation. The interpersonal coping strategies most cited by adolescents seemed to corroborate that this perceived isolation worked as a self-imposed one: they were able to access meaningful relations as a way of promoting emotional relief in different moments of distress.

This is in accordance with the centrality of the idea of the fracturing of the social connectedness with family and friends. It is worth noting that while social norms encourage strong relations with parents and friends, depressed adolescents find themselves unable and unwilling to accept this shared optimism. Therefore, understanding this self-isolation seemed to be relevant to the context where the research was carried out.

These perceptions are interesting from both cultural and cognitive aspects: first, the idea of the development of cultural identity may be stronger among adolescents—they are experiencing, firsthand, the idea of balancing relationships with family and friends—then, these reports may shed light on a manifestation of cognitive bias in depression. While we did not find strong ties between isolation and feelings of loneliness in our data, we could argue that this self-isolation could lead to anticipating social rejection—and this, in turn, may lead to feelings of loneliness (Achterbergh et al., 2020)—working almost as a self-fulfilling prophecy. Moreover, it is worth noticing that isolation does not necessarily foster loneliness—it has been theorized that it does for those who interpret it as a reflection of their own limitations (Laursen & Hartl, 2013).

It is interesting that isolation was highlighted by our sample of adolescents. While the number of participants in our study was similar across both genders (6 girls and 5 boys), studies carried out in WEIRD countries identified social withdrawal as more common for boys and loneliness for girls (Crowe et al., 2006). This may be due, however, to the fact that our study was not designed to explore loneliness as an experience *per se*. It is also worth noticing that experiences of loneliness may vary in different demographic and cultural groups (Achterbergh et al., 2020), and our sample comprised adolescents from a specific age group.

Finally, while adolescents most strongly described isolation, having different sources of data also contributed to the identification of isolation as a core component of adolescent depression. The perspectives of parents, health providers and educators were also sources of important insights into how adolescent depression is perceived by these groups. Shedding light on isolation, therefore, also points to a culturally relevant indicator of adolescent depression.



Another important point related to the adolescent experience of depression was the importance attributed to relationships as a source of support when facing depressive feelings. While formal healthcare settings were not mentioned expressively by adolescents as a viable source of support while facing these feelings—limited to moments where barriers were mentioned, such as long queues—adolescents referred to having someone to talk to as one of the most immediate choices for relieving bad feelings. Overall, the family system was the basic structure upon which the adolescent expected to rely when in distress.

Although having a group of friends was understood as promoting a sense of safeness, inclusion, and understanding, it can also be associated with an increase of risk-taking behaviours, such as drinking and cigarette use (Andrews et al., 2020). Additionally, bullying was mentioned by adolescents as an important peer-related issue. This is a relevant factor that was not explored in detail in our study. While the literature shows that both bullies and victims have elevated rates of childhood psychiatric disorders that extend to young adulthood (Copeland et al., 2013), the causal effect adolescents attribute to bullying shows that adolescents may be more aware of the consequences of this victimization than previously theorized (Pigozi & Machado, 2015). Moreover, it shows that while peers may be a source of comfort, they can also play an important role in threatening positive social relationships.

From the observations of the adolescents' understanding of how to cope with depression, we can see that actions directed to emotion regulation by means of engaging in contact with people close to them were the principal source of relief. This finding is consistent with another study with Brazilian adolescents: Libório and Ungar (2014) found that positive relationships with significant community members emerged as a protective factor in working adolescents (Libório & Ungar, 2014).

Additionally, gender-specific differences in coping mechanisms were cited by respondents. These accounts highlight the importance of understanding the influence of gender on depression—gender-specific attributes and socialization can influence the development of depression in adolescents (Wisdom et al., 2007), and understanding these differences may be important to defining and structuring interventions, for example, (Marcotte et al., 2002).

Based on a developmental system relational approach, Osher et al. (2020) highlighted the important role that relationships have as the primary process of development balancing intrinsic and contextual factors. Interactions based on information, communication, support, and empathy attunement are important to promote positive development. In

this sense, adolescents in this study expressed the need to engage in relationships that reciprocated what was happening to them. Either by concrete experiences of difficulties with adults in their immediate context or by their own difficulties in engaging with others, there was a fracture in their ability to feel (and be) supported and nurtured.

#### **4.1. Implications for identification and management of adolescent depression**

Since the notion of social interaction was described as a basic source of resilience, interventions in different contexts of adolescent life should enhance the promotion of a supportive environment. First, it is essential to address knowledge gaps in communities. Actions directed to raising awareness of signs and symptoms in the family and school context could improve the correct identification of the adolescents' needs. In this sense, the identification of depression plays an important role to lessen the burden and impact of a mental health problem in their lives. Moreover, it highlights a need for better understanding and listening to the voices of young people—they report not feeling heard. Therefore, it seems that adults need to proactively ask adolescents how they are feeling and offer support, surpassing assumptions, and preconceptions they may have.

Purposefully addressing the need for social connectedness in adolescents by focusing on interventions that offer alternative social experiences as well as educational resources would also be helpful. Adolescents are less likely to engage in risky behaviour if a friend discourages them from doing so (Maxwell, 2002), therefore, repurposing peer influence may also address gaps in the identification and management of depression among peers, encouraging help-seeking behaviours and decreasing stigma. Focusing on encouraging problem-solving coping skills could also play a role in both the prevention and management of depression (Mynors-Wallis et al., 2000).

Improving communication, family functioning and bonding can be a way of preventing depression, mitigating its impacts, and increasing self-reflection in both parents and adolescents (Elsina & Martinsone, 2020). Moreover, there is an urgent need to improve access to healthcare settings: the interviewed adolescents did not see primary care providers and other services as a source of support when in distress. These findings resonate with previous studies on access to mental health care for children and adolescents in Brazil (Amaral et al., 2018; Fatori et al., 2019), and indicate a need for adolescent-friendly health services.

Additionally, approaches centred on interpersonal relationship issues (e.g., interpersonal psychotherapy) could represent a compelling approach to both

prevent/decrease depressive symptomatology and to improve interpersonal functioning (Klerman et al., 1984). There is evidence to support the effectiveness of interpersonal psychotherapy (IPT) among adolescents in LMICs (Bolton et al., 2007). And the focus on social experience in IPT lends itself well to cultural adaptation for adolescents in diverse settings (Rose-Clarke et al., 2020). On this note, a model of adolescent depression that highlights social interactions may also contribute positively to early identification and management of depression (see Figure 2 for highlights).

#### 4.2. Limitations

Despite contributing to decreasing a gap in the qualitative literature on adolescent depression in Brazil, our study must be interpreted in the context of some limitations. First, it included a limited number of adolescents and other stakeholders sampled by convenience. Therefore, it provides the views of only some individuals residing in certain community settings located in the city of Porto Alegre. Even though we highlighted the importance of schools as a place of socialization and peer interaction, we acknowledge that other community settings may be better suited for interventions directed to peer relationships. This limitation, however, stems from sampling and data analysis choices that focused on educational and healthcare scenarios.

In Brazilian Portuguese, as in many other languages, “depression” is a common way of referring both to feelings of sadness and to a formal psychiatric diagnosis. In this study, however, we did not distinguish and/or probe for these linguistic differences, so

the word was used in a broader way. This can result in perspectives that are biased by cultural and contextual norms and that do not refer specifically to clinical depression.

Moreover, in this paper we focused on the accounts and experiences of adolescents and their parents as guides to data analysis and reporting. However, we acknowledge that depression occurs in a wider context that involves other stakeholders. Therefore, subsequent studies focusing on other stakeholders’ perspectives are required—and, since our study design enables such comparison of perspectives, we plan to develop such studies in the future. Additionally, our paper did not specifically assess gender differences in perceptions and experiences of depression, rather adopted a group-oriented approach that was, unfortunately, less sensitive to these differences. Further exploration of gender and gender roles and its influences on adolescent depression in Brazil are also required.

It is also important to acknowledge that our analysis was mostly driven by the professional background of the researchers, focusing on clinical components and perceived signs and symptoms of adolescent depression. Lastly, it is important to highlight that Porto Alegre has several cultural and socioeconomical specificities that are constrained to the South of Brazil, and thus it is impossible to assess whether the described perceptions and experiences necessarily extends to other adolescents in different contexts in Brazil.

#### 5. Conclusion

In this study, although the description of adolescent depression symptoms resonated with studies

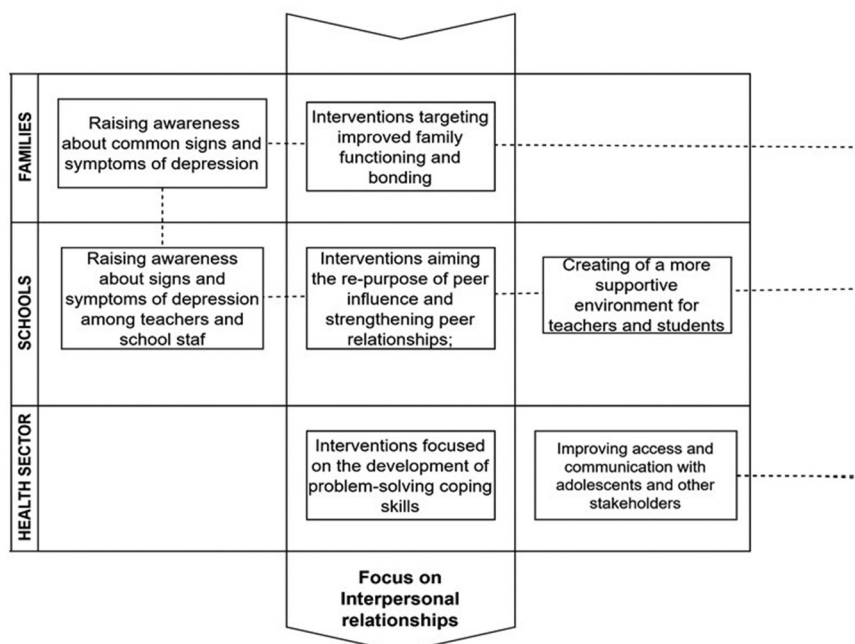


Figure 2. Identifying depression across different settings in Brazilian location.

conducted in HIC, the isolation component of depression highlighted the importance of social relationships—especially within families—in adolescents' lives. Thus, isolation was a central component of the perceived experience of depression and was related both to the individual and interpersonal experiences. Moreover, this sense of isolation was not seen as a symptom, but as a way of solving the problems that arose from the experience of disruption caused by depression. By taking into account social and cultural aspects of adolescence, as well as the background in which adolescents are immersed, the recognition and systematic exploration of subjective perspectives might allow the development of culturally relevant, adolescent-centred mental health care systems, and hopefully contribute to the early identification and intervention for depression in adolescence.










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### ORCID

Anna Viduani  <http://orcid.org/0000-0002-6289-6397>  
 Silvia Benetti  <http://orcid.org/0000-0001-8557-2216>  
 Thaís Martini  <http://orcid.org/0000-0003-4644-2501>  
 Claudia Buchweitz  <http://orcid.org/0000-0002-6213-9724>  
 Katherine Ottman  <http://orcid.org/0000-0002-8233-8472>  
 Syed Shabab Wahid  <http://orcid.org/0000-0003-0355-0537>  
 Helen L. Fisher  <http://orcid.org/0000-0003-4174-2126>  
 Valeria Mondelli  <http://orcid.org/0000-0001-8690-6839>  
 Brandon A. Kohrt  <http://orcid.org/0000-0002-3829-4820>

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## Appendix A Original quotes in Brazilian Portuguese

Original Quote in Brazilian Portuguese	Translated quote
"E eles acham que a gente não tem problemas. [...] Eu tenho problemas e eu tenho impressões e são muito mais que as de vocês, porque vocês têm as impressões de vocês e ainda impõem as impressões de vocês na gente."	"They think [parents and school workers] we don't have problems. [...] I have problems and I have thoughts that are much more than what you think, because you [adults] have your own impressions and impose these impressions on us [adolescents]" (Adolescent 3, male, 15)
"Ah, eu senti um vazio, senti que eu não queria mais nada com nada. Tipo, não queria mais fazer nada, não queria mais estudar, não tinha mais vontade de conversar com ninguém, não queria mais ser amiga de ninguém. Queria só ficar quieta na minha."	"I felt empty, like I didn't want anything else. I didn't want to do anything, I didn't want to study or talk to anyone, I didn't want to be friends with anybody. I just wanted to be quiet, and be by myself." (Adolescent 6, female, 15)
"Sentir um vazio, não se sentir mais feliz, ou não querer mais aquilo que tu gostava de fazer antes. Eu gosto de ler, gosto de ver série, e às vezes ... Às vezes, não tenho ânimo, sabe? Daí, se é uma coisa recorrente, eu vejo que tem uma coisa errada, pode até ser uma depressão."	"You feel empty, not happy anymore, with no desire to do things you liked before. I like to read, to watch TV shows, but sometimes I don't feel like doing these things, I have no will. Then, if it is something recurrent, I see that there's something wrong, I may be depressed." (Adolescent 8, female, 15)
"É difícil não fazer besteira. Tipo, usar drogas, coisas assim, ou até tentar se matar. Foi um desafio muito grande, muito grande mesmo. A vontade teve."	"It's hard not to mess things up. Doing bad stuff (...) like killing yourself. It's a big, big challenge. I wanted to." (Adolescent 6, female, 15)
"Pois é, eles acham que só estar perto é bom, que a gente não precisa conversar, ver como são os problemas. Eles acham que porque um adolescente não tem contas pra pagar a gente não tem problemas."	"They think that just being around is enough, and that we don't need to talk about our problems. (...) They think that just because we don't have bills to pay, we don't have any problems." (Adolescent 2, male, 16)
"Não sei se isso é uma coisa específica do Brasil, mas bullying é uma das principais causas. A pessoa já está enfrentando bastante e ainda por cima sofre bullying. Adolescentes querem ser parte de um grupo, mas quando eles precisam enfrentar o bullying, eles se sentem ameaçados."	"I don't know if this is specific to Brazil, but bullying is one of the main causes. The person is already facing a lot, and on top of that, suffers bullying. The adolescent wants to be part of a group, and when they face bullying, they feel threatened." (Adolescent 1, female, 14)
"E quando tem um problema, assim, que nem, a minha frequência baixou na escola bastante [...] não teve um professor que chegou em mim e disse assim, 'está acontecendo alguma coisa, que tu está faltando?' Não. A única coisa que eu ouvi foi 'ah, tu vai rodar, porque tua frequência está baixa. Ai, mas tu só falta aula.' Foi as únicas coisas que ouvi."	"When there is a problem—like when I had a school attendance problem, [...] not one teacher came to me and said, 'hey, is there something happening, why are you missing school?' No. The only thing I heard was 'oh, you're going to fail, your attendance is low. Oh, you never come to class.' That was the only thing I heard." (Adolescent 7, female, 17)
"Eu fiquei pensando no sentindo, assim: tristeza. Que ideia tu tem de tristeza? Que que é triste? Que conceito tu tem de triste? Porque talvez eu, enquanto mãe, entenda que ser triste é ficar com aquele semblante, quietinho ... e pra ele não."	"What I'm thinking is that sadness ... What do you think depression is? What is sadness? What are your conceptions of sadness? Because I, as a mother, understand that being sad is looking down, being quiet ... And to him, it isn't." (Mother 8)
"Eu notei que ela estava mais fechada tanto que eu achei que fosse por causa da adolescência em si, né, não, ela está se fechando, porque ela sempre teve uma relação muito boa ... E daí eu achava ela muito triste, ela não era assim. Ela sempre foi sempre muito falante, muito alegre, sempre disposta a ajudar tudo e todos. Comecei a notar que ela estava mais para baixo, assim, mais quieta, na dela."	"I noticed that she was more closed, but I thought it was just a teenager thing, because of adolescence ... But, she is getting more closed, and she always had a good relationship with me. (...) And I noticed she was sad, she was not like that. She used to be talkative, happy, always ready to help everyone. I noticed she was down, quiet, in her own world." (Mother 4)
"Tipo um atraso. Um atraso que, querendo ou não, é um momento que tu perde a vontade de fazer as coisas. (...) E não é porque tu quer, é só porque tu não está sabendo lidar. Tu não tá sabendo lidar com o teu trabalho, tu não tá sabendo lidar com os seus amigos, tu não tá sabendo lidar com os teus estudos. Tu não consegue evoluir porque tu só está retrocedendo ..."	"It's like a delay. It's a delay that, liking it or not, is a moment you lose all the will to do stuff. (...) And it's not because you want to, it's just because you don't know what to do. You don't know how to deal with your friends, you don't know how to deal with your studies ... You can't develop because you're going backwards ... " (Adolescent 7, female, 17)
"Parece que tudo é difícil, parece que tudo te afunda mais."	"Everything's hard, it seems like everything makes you sink deeper." (Adolescent 4, female, 15)

(Continued)

(Continued).

Original Quote in Brazilian Portuguese	Translated quote
<p><i>"Tem alguns que não querem ir. Tem alguns que vão para a escola, mas acabam ficando isolados ou ... tem outros que se expressam de outras formas, também. (...) E ... tem outros que enlouquecem, né, surtam e ... ou não param de rodar na escola. Cada um acho que é de um jeito."</i></p>	<p><i>"There are some who don't want to go [to school]. There are some that go but end up being isolated, there are those who find other ways to express themselves too. [...] And there are others who go crazy, freak out and ... Fail school again and again." (Social Worker 5, female)</i></p>
<p><i>"É fortíssimo, né. Como, por exemplo, é muito comum a gente receber adolescentes que já passaram pelo plantão. O primeiro impacto é ser considerado louco e se considerar louco."</i></p>	<p><i>"[The impact of a crisis] is really strong. For example, we get many adolescents coming from the ER. The first impact is being considered as crazy and considering themselves crazy." (Health Worker 4, female)</i></p>
<p><i>"Quero ficar sozinha". A primeira vez, eu só pensava quero ficar sozinha, só quero ficar sozinha, quero ficar no meu canto sozinha. Só conseguia pensar ... Que quero ficar sozinha."</i></p>	<p><i>"I want to be alone. The first time [first depressive episode], all I could think was that I wanted to be alone, wanted to be in my own corner. All I could think about ... I want to be alone." (Adolescent 6, female, 15)</i></p>
<p><i>"Eu não queria mais nada com nada. Tipo, não queria mais fazer nada, não queria mais estudar, não tinha mais vontade de conversar com ninguém, não queria mais ser amiga de ninguém. (...) E acaba ficando brabo também."</i></p>	<p><i>"I didn't want anything at all: I didn't want to do anything, I didn't want to study, I didn't want to talk to anybody, I didn't want to be friends with anybody anymore. (...) And you end up being mad too." (Adolescent 6, female, 15)</i></p>
<p><i>"Eu já convidei várias vezes ela pra sair, ir na minha casa, ou no cinema, e ela sempre recusava"</i></p>	<p><i>"I have invited her to go out several times, go to my house, or even go the movies ... But she always refused." (Adolescent 8, female, 15)</i></p>
<p><i>"Eu não sei dizer, fiquei meio ... Meio preso. Com alguma coisa, assim, dentro de mim, assim, para tirar. Como ... Um peso. Daí, eu fico muito angustiado e fico pensando nisso."</i></p>	<p><i>"I don't know how to explain, I felt ... trapped. Like there was something inside me I couldn't get rid of. Like a weight on me. And I would get really upset." (Adolescent 3, male, 15)</i></p>
<p><i>"Não querer marcar programas com eles, e se marcam acham sem graça e se vão acham que não foi legal, ou só fala mal do que aconteceu no programa ou dos guris com quem estavam. Nada está bom, é o tempo todo isso- comportamento de reclamação, de não adequação. E muitas vezes ligada a evitação, que vai entrando num ciclo que tudo é ruim e ele [adolescente] começa a nem ir."</i></p>	<p><i>"They don't want to hang out with their friends, and if they do, they don't see it as something nice, they just complain about what happened in the outing. Nothing is good, and it's all the time—they complain, they don't feel adequate. This is often linked to avoidance, which spirals into a bad cycle, and the adolescent doesn't even try to go out anymore." (Health Worker 3, female)</i></p>
<p><i>"Eu acho que, por causa da depressão, a pessoa se isola e pensa que não tem solução para os seus problemas, e que ninguém mais está na mesma situação, que ninguém consegue entender seu sofrimento."</i></p>	<p><i>"I think that because of depression, a person isolates themselves and thinks that there are never any solutions for their problems, and that no other person is in the same situation, that people can't understand their suffering." (Adolescent 1, female, 14)</i></p>
<p><i>"Se sentir triste, tipo, não ... Se sentir sozinho, sei lá, não ter vontade de viver ... Isso ... Acho que são alguns sintomas que tu está com depressão."</i></p>	<p><i>"Feeling very sad and very lonely. Having no will to live. This ... I think these are the signs you are depressed." (Adolescent 4, female, 15)</i></p>
<p><i>"A minha filha também, quarto, quarto, quarto. Não pega sol no nosso apartamento, só pega de manhã durante 20 minutos, é uma tristeza. E eu digo assim, 'A gente tem que sair, ficar num sol, né, vamos sair, nem que seja no supermercado, mas tu tem que pegar sol', daí ela fica sempre deitada, assim, no celular. Eu me preocupo, sabe?"</i></p>	<p><i>"My daughter just stays in her room. We don't have direct sunlight in our apartment, just in the morning for 20 minutes, it's sad. And I tell her we have to go out, even if it's just to the supermarket, but she is always lying down, using her phone. I worry about her a lot." (Mother 2)</i></p>
<p><i>Eu, ultimamente, quando fico mal, eu tento olhar mais pelo lado positivo. Aí eu vejo que, tipo, não é só aquilo, que existem coisas boas(...) Converso com minha prima, também, tipo ... Que é bom desabafar.</i></p>	<p><i>"Lately, when I feel bad, I try to look more on the positive side. Then I see that it's not just that, that there are good things (...) I talk to my cousin, too, like ... It's good to let off steam." (Adolescent 5, female, 14)</i></p>
<p><i>"Tem horas que é insuportável estar perto das pessoas, mas tem horas que eu não quero que elas vão pra longe de mim."</i></p>	<p><i>"There are moments when it is unbearable to be around people, but there are moments when I don't want them to go away from me." (Adolescent 2, male, 16)</i></p>
<p><i>"No psicólogo também, eu que tomei a iniciativa de ir no psicólogo, porque eu senti a necessidade de dividir os meus problemas com um profissional."</i></p>	<p><i>"At the psychologist too, I took the initiative to go to the psychologist, because I felt the need to share my problems with a professional." (Adolescent 8, female, 16)</i></p>
<p><i>"Muita gente se corta. Procurando algum tipo de alívio. Teve gente também ... Até artista, que se fugiu para as drogas, não aguentava mais ter dor e fugiu para as drogas."</i></p>	<p><i>"A lot of people self-harm. Looking for some sort of relief. There's also people ... Even artists, that scaped into drugs, they could not face being in pain anymore and escaped into drugs." (Adolescent 3, male, 15)</i></p>
<p><i>"Olha, as meninas elas são, elas, elas tentam se unir mais para poder uma ajudar a outra. Então, elas tentam ser mais unidas, as meninas. E aí, uma tenta consolar a outra, às vezes. Às vezes tem o lado positivo também. Às vezes, uma coleguinha diz 'não, vai lá em casa, a mãe te ajuda, minha mãe te ajuda, e tal'. Então, as meninas, elas ainda têm mais, assim, união. Já os meninos, como eles são muito individualistas."</i></p>	<p><i>"Look, the girls they are ... They try to unite so they can help each other [...] They are more united. They comfort one another sometimes. There's a positive side to it. Sometimes one girl says to another 'no, you can go to my home, my mom can help you'. Girls unite themselves more, while boys are individualistic." (Educator 5, female)</i></p>
<p><i>"Positiva é a fala, quando conseguem falar disso, falar nos grupos, falar com o grupo da escola, sobretudo na família—ter alguém que escute na família. Eu acho que essa é uma estratégia de enfrentamento muito positiva."</i></p>	<p><i>"Positive [coping strategy] is talking, when they manage to talk about their feelings in groups, but mostly in the family—and having someone that listens in the family. I think this is a very good coping strategy." (Father 1)</i></p>

## Appendix B Complete framework of codes used for the creation of themes, stratified by respondent

Codes >	Adolescents	Parents	Social Workers	Health Workers	Educators	Policy Makers
Signs & Symptoms of Depression	- Loneliness and Social Isolation linked to anhedonia and suicidal ideation - Feeling empty and overwhelming cognitive symptoms - Feelings of sadness	- "Not wanting to do things" - Irritable mood - Spending too much time in the room and withdrawing from family convivence - Crying a lot - Self-harm - Weight loss/gain	- "Not wanting to do things" - Irritable and sad mood - Crying a lot - Self-harm - Weight loss/gain	- "Not wanting to do things" - Irritable mood - Self-harm - Weight loss/gain	- "Not wanting to do things" - Sad mood - Self-harm - Changing the way they look: "wearing sweaters all the time"	- Anhedonia - Sad mood
Depression vs. Other Experiences	- Depression sticks to you like a scar; - Most symptoms go unnoticed.	- Generation issues: what's sadness to adolescents?	- Depression is a loss of will and ability to deal with adverse situations, while this does not happen in sadness	- Depression is a loss of will and ability to deal with adverse situations, while this does not happen in sadness - Intensity, impact and duration	- Depression is persistent (length) - Depression impairs functioning	- Intensity, impact and duration
Impacts of Depression	- Isolation from peers - Increased inability to deal with adverse life situations - Problem in relation with parents and peers - Delay in development - Impaired school performance	- Isolation from peers - Impairment in school performance, dropout - Suicide	- Isolation from peers - Impairment in school performance - Self-harm/suicide - Difficulty in maintaining relations	- Isolation from peers - Suicide - Impairment in school performance	- Self-harm /suicide - Impairment in school performance - Isolation from peers	- Self-harm /suicide - Impairment in school performance, dropout
Coping Strategies	- Individual level: writing and having positive thoughts - Relational strategies: discussing problems with family members - Engaging in social networking - Distraction activities - Negative coping strategies: use of cigarettes, alcohol consumption and doing drugs.	- Positive coping strategies: talking about emotional issues with parents and peers - Leisure time, sports - Negative coping strategies: bad peer influence, running away	- Positive coping: talking with parents and asking for help - Group strategies - Negative coping: self-harm and suicidal ideation - Drug and alcohol abuse	- Positive coping strategies: group support, looking for help - Talking parents and peers - Negative coping strategies: suicide attempts - Drugs - Isolation	- Positive coping: asking for help, support from family and friends - Negative coping strategies: drugs - Denying they need help - Self-harm	N/A

## Appendix C Consolidated criteria for reporting qualitative research

Topic	Item No.	Guide Questions/Description	Page No.
<b>Domain 1: Research team and reflexivity</b>			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	6
Credentials	2	What were the researcher's credentials? E.g., PhD, MD	6
Occupation	3	What was their occupation at the time of the study?	6
Gender	4	Was the researcher male or female?	6
Experience and training	5	What experience or training did the researcher have?	6–7
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	5
Participant knowledge of the interviewer	7	What did the participants know about the researcher? E.g., personal goals, reasons for doing the research	5
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? E.g., Bias, assumptions, reasons and interests in the research topic	7–8
<b>Domain 2: Study design</b>			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? E.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	5–7
<i>Participant selection</i>			
Sampling	10	How were participants selected? E.g., purposive, convenience, consecutive, snowball	4–5
Method of approach	11	How were participants approached? E.g., face-to-face, telephone, mail, email	4–6
Sample size	12	How many participants were in the study?	4–5
Non-participation	13	How many people refused to participate or dropped out? Reasons?	4–5
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? E.g., home, clinic, workplace	6–7
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	6
Description of sample	16	What are the important characteristics of the sample? E.g., demographic data, date	4–6
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	5
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N.A.
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	6
Field notes	20	Were field notes made during and/or after the interview or focus group?	6–7
Duration	21	What was the duration of the inter views or focus group?	6–7
Data saturation	22	Was data saturation discussed?	4, 7
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	N.A.
<b>Domain 3: analysis and findings</b>			
<i>Data Analysis</i>			
Number of data coders	24	How many data coders coded the data?	7
Description of the coding tree	25	Did authors provide a description of the coding tree?	7–8,
<b>Appendix B</b>			
Derivation of themes	26	Were themes identified in advance or derived from the data?	7
Software	27	What software, if applicable, was used to manage the data?	7
Participant checking	28	Did participants provide feedback on the findings?	N.A.
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g., participant number	9–20
Data and findings consistent	30	Was there consistency between the data presented and the findings?	20–25
Clarity of major themes	31	Were major themes clearly presented in the findings?	19–25,
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Figure 1 16, 19–21

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349–357