Not all depressive symptoms matter equally:

Ratings of the relative importance of nine DSM symptoms in a sample of Indian adolescents

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Abstract

Background: There is widespread debate about the extent to which western diagnostic criteria for depression are appropriate cross-culturally. A key aspect of this debate involves the extent to which individual symptoms are considered important, impairing, and concerning by individuals in low- and middle-income countries. Here, we describe a novel method to understand the degree to which symptoms of depression are most important to individuals, and we illustrate its application in a non-western sample.

Methods: We surveyed 1,237 Indian adolescents (47.8% female, $M_{age}= 14.11$). Adolescents received the Patient Health Questionnaire-9, a measure of nine DSM-derived depressive symptoms. For each symptom, participants answered three questions designed to assess the degree to which they perceive the symptom as distressing and impairing. The three scores were averaged to form a Subjective Importance Rating (SIR) for each symptom.

Results: Anhedonia received the highest SIR, followed by Sad Mood, Suicidal Ideation, and Feeling like a Failure; Psychomotor Problems received the lowest SIRs. Females reported greater SIRs than males, and older students reported greater SIRs than younger students. There was a non-linear relationship between participants' own depressive symptoms and SIRs.

Limitations: Participants were recruited from the general population; findings may not generalize to patients or individuals in other countries.

Conclusion: Not all symptoms of depression were viewed as equally important. We discuss how the SIR approach can help global mental health researchers identify specific symptoms that are considered most concerning, evaluate the cross-cultural relevance of western diagnostic criteria, and inform the validation of measurement tools.

Keywords: Depression symptoms; measurement; DSM; major depressive disorder; cross-cultural assessment; global mental health

Introduction

Depressive symptoms are a leading cause of disability worldwide (Ferrari et al., 2013). Depressive symptoms are especially common among adolescents in low-and middle-income countries (LMICs), who often face academic, psychosocial, and economic pressures while lacking access to support (Patel et al., 2007). While it is understood that depression can be expressed and conceptualized differently in different cultures (e.g., Haroz et al., 2017; Wilk & Bolton, 2002), limited research has examined if and how individuals in non-western cultures evaluate depressive symptoms as defined in western diagnostic taxonomies. Such information could inform debates about the best way to understand psychopathology in non-western cultures and could be used to develop culturally appropriate interventions. If the same symptoms originating from western diagnostic criteria are considered important priorities in non-western cultures, this pattern of findings would suggest that targeting these symptoms would meaningfully improve the lives of individuals in non-western cultures. However, if some or most symptoms from western taxonomies are considered unimportant, efforts to target these symptoms may not be as culturally relevant or impactful.

In addition to these important cultural considerations, depression as a construct has also been recently challenged on psychometric grounds. Empirical research has highlighted the fact that depression is not well-characterized as a single consistent syndrome (Fried et al., 2014; Fried & Nesse, 2015). These findings have prompted some psychometricians to advocate for the analysis of individual symptoms, rather than total scores or sum scores on depression measures (Fried & Nesse, 2015). One approach to symptom-level analyses is network analysis, in which a high centrality value, which reflects strong connections to other symptoms, indicates that a symptom is important within the network (Borsboom, 2017; McNally, 2016).

Another approach is to examine the associations of variations in individual symptoms with other variables of interest, such as psychosocial functioning. In one study, hypersomnia explained less than 1% of the variance in depression-related impairment, whereas sad mood explained 21% of the variance (Fried & Nesse, 2014). Each of these approaches can be used to suggest which symptoms are “more important” or “worthier to target,” and both approaches reject the sum score approach that is typically used in analyses, in which each depressive symptom on a scale is weighted equally to contribute to a sum score.

Here, we propose a novel—and complementary— approach to examining the importance of individual symptoms. Our approach involves asking individuals themselves to rate how important each depressive symptom is. We name this approach the *Subjective Importance Rating* (SIR), as it yields an individual’s assessment of how important various depressive symptoms are. In our view, an emphasis on subjective importance is especially useful in non-western contexts, where investigators may be unsure about the extent to which individuals will place value on symptoms that are identified and defined via a western diagnostic model (see Summerfield, 2008). However, we see the implications of subjective importance far beyond cross-cultural research—an investigation of subjective importance is useful any time in which individuals may have different views on the importance of different depressive symptoms.

In this paper, we describe the development of an SIR measure and its administration to a large sample of Indian adolescents. We then present overall SIR values for each of the nine depressive symptoms assessed with the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001), a measure of depressive symptoms that is based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for depression. Finally, we explore

potential differences in SIR ratings as a function of gender, age, and participants' own level of depressive symptoms.

Method

Participants

We used data obtained at baseline as part of a randomized controlled trial of online mental health promotion interventions conducted in three high schools in Maharashtra, India (see Wasil, Park, et al., 2020). Briefly, eligible participants were adolescents (grades 7 to 12) attending secondary schools in Maharashtra. Study procedures were approved by the Sangath Institutional Review Board. Sangath is a non-governmental organization in India that regularly performs health and mental health promotion research in community settings.

Baseline data were collected from June to August of 2019 from 1,360 students. The survey included two attention checks; we excluded participants who failed both attention checks ($n=123$), leaving us with a sample of $n=1237$ (47.8% female). Participants ranged in age from 11-years-old to 18-years-old ($M_{\text{age}} = 14.11$, $SD = 1.48$). The mean PHQ-9 score for these adolescents was 8.11 ($SD=4.99$).

Measures

The baseline questionnaire consisted of standardized measures of depressive symptoms, perceptions about the importance of these symptoms, and demographic information (e.g., age, gender).

Depressive Symptoms (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9) is a commonly used measure of depressive symptoms. The items of the PHQ-9 correspond directly to the criteria for major depressive disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013). The

PHQ-9 has demonstrated strong reliability (Cronbach's alpha of .86-.89) and validity (Kroenke & Spitzer, 2002), and it has been validated in a sample of Indian adolescents (Ganguly et al., 2013). Example items from the PHQ-9 include "little interest or pleasure in doing things" and "thoughts that you would be better off dead, or of hurting yourself." Participants are asked to rate the frequency of each item over the past two weeks. Items are scored from 0 ("Not at all") to 3 ("Nearly every day").

Subjective Importance Rating Scale

We developed a subjective importance rating scale. For each of the nine symptoms of the PHQ-9, we prompted participants with three items:

- 1) Please indicate how important or concerning you find this problem.
- 2) Imagine you were experiencing this problem. How would it affect your overall happiness or well-being?
- 3) Imagine you were experiencing this problem. How much would you want it to go away or get better?

Each item was rated on a slider scale from 0 ("Not so important or concerning" for item 1; "Not so much" for items 2 and 3) to 100 ("Extremely important or concerning" for item 1; "Very much" for items 2 and 3).

Participants rated each of the three items for each of the nine PHQ symptoms, resulting in 27 total subjective importance ratings.

Analyses

We estimated hierarchical linear models (HLMs) with the SIR as the dependent variable, with random intercepts for each participant. As predictors, we examined gender, age, and PHQ-9 score. We planned to evaluate linear effects; however, upon visualizing our data, we observed a

potential non-linear effect of participant PHQ-9 score on SIR values. As a result, we decided to evaluate models with linear and quadratic effects of our two continuous variables (PHQ-9 score and age). As explained below, we compared the performance of models with linear terms to models with linear and quadratic terms.

Our models included terms for gender (“centered”, such that male was coded as -0.5 and female was coded as 0.5), age (centered), squared age, PHQ-9 score (centered), squared PHQ-9 score (to evaluate a quadratic effect of depressive symptoms on SIR values), and the symptom that was rated (e.g., anhedonia, sadness). To explore potential interactions, we also evaluated models that included interaction effects: gender*symptom, age*symptom, PHQ-9 score*symptom, and squared PHQ-9 score*symptom. To identify the model with the best performance, we used Bayesian Information Criterion (BIC) values. The BIC is a common method for comparing multiple non-nested models, and it penalizes more complicated models in order to avoid overfitting (see Dziak et al., 2020).

As expected based on our data visualization, the model with the best performance (as indicated by BIC values) included a quadratic term for PHQ-9 score. To confirm that the model with squared PHQ-9 score performed better than the model with only a linear term PHQ-9 score, we performed a chi-square test to examine if the differences in performance between the models were statistically significant. This approach was possible because the two models were nested. Consistent with the BIC approach, the chi-square test revealed model with the quadratic term was preferred over the model without the quadratic term; $X^2(1, N=1,237) = 68.7, p < 0.001$. In summary, our data visualization, BIC comparison, and significance-testing approaches each favored the model with a quadratic term for PHQ-9 score.

The model with the best performance included the following predictors: gender, age, PHQ-9 score, squared PHQ-9 score, symptom, and the gender*symptom interaction effect. To investigate statistically significant effects, we compared means using Tukey's honestly significant difference (HSD) method to correct for multiple comparisons.

Results

Internal Consistency of Subjective Importance Ratings

As mentioned, our subjective importance rating scale consisted of three items. To evaluate the internal consistency of the scale, we calculated Cronbach's alphas. Because we expected consistency for subjects' ratings of a given symptom, we calculated a separate alpha for each symptom that was rated. SIR scores showed adequate internal consistency on all symptoms ($\alpha > 0.60$), ranging from $\alpha = 0.69$ (anhedonia) to $\alpha = 0.83$ (feeling like a failure).

Do some symptoms receive higher subjective importance ratings than others?

Our hierarchical linear model revealed a main effect of symptom, indicating that symptoms differed in importance ratings ($p < 0.001$; Table 1). Pairwise comparisons, using Tukey's HSD method, indicated that there were five distinguishable groups of symptoms. SIR values did not differ significantly among symptoms in the same group, and SIR values did differ significantly among symptoms that were from different groups. The five groups, in order from highest SIR values to lowest SIR values, were: Group A (Anhedonia), Group B (Sad Mood, Suicidal Ideation, and Feeling like a Failure), Group C (Low Energy and Sleep Problems), Group D (Concentration Problems and Appetite Changes), and Group E (Psychomotor Problems).

Figure 1 displays the SIR values for each symptom.

Table 1

Mixed-Effect Regression Model with Symptoms, Gender, Age, and PHQ-9 Score as Predictors for SIR Scores

<i>Fixed Effect</i>	SIR Value		
	<i>B</i>	<i>SE</i>	<i>p</i>
Intercept (Anhedonia)	53.2	0.94	<0.001
Appetite	-17.3	0.83	<0.001
Concentration	-16.1	0.83	<0.001
Energy	-11.3	0.83	<0.001
Failure	-6.0	0.83	<0.001s
Motor	-20.3	0.83	<0.001
Sadness	-5.9	0.83	<0.001
Sleep	-13.3	0.83	<0.001
Suicide	-5.9	0.83	<0.001
Gender (centered)	0.8	1.6	0.6
Age (centered)	2.4	0.4	<0.001
PHQ-9 (centered)	0.09	0.13	0.50
Squared PHQ-9	0.16	0.02	<0.001
Appetite*Gender	4.7	1.7	0.004
Concentration*Gender	3.9	1.7	0.02
Energy*Gender	5.4	1.7	0.001
Failure*Gender	11.5	1.7	<0.001
Motor*Gender	4.8	1.7	0.004
Sadness*Gender	10.4	1.7	<0.001
Sleep*Gender	5.1	1.7	0.002
Suicide*Gender	11.2	1.7	<0.001

<i>Random Effect</i>	<i>Variance</i>	<i>Standard Deviation</i>
Participant ID	373.9	19.34
Residual	409.1	20.23

Caption: Table 1 shows the results of a mixed-effect regression model, with Subjective Importance Ratings as the dependent variable. The symptom rated (a factor with nine levels), gender (coded -0.5 for males and +0.5 for females), age (centered at the mean value), depressive symptoms (centered at the mean value), squared depressive symptoms, and the symptom rated were entered as predictors. A random intercept was included for ID (to account for the fact that each participant provided nine sets of subjective importance symptom ratings—one for each symptom). Possible scores on the PHQ-9 range from 0 to 27, with higher scores indicating greater depressive symptoms. P-values <0.05 are bolded.

Figure 1

Subjective Importance Ratings by Symptom

Caption: Figure 1 shows the estimates of subjective importance ratings for each symptom. Error bars represent ± 1 standard error. The labels indicate distinguishable groups. SIR values did not differ significantly among symptoms in the same group, and SIR values did differ significantly among symptoms that were from different groups

Subjective Importance Ratings by Gender

The HLM revealed a significant gender*symptom interaction effect ($ps < 0.001$; Table 1). To follow-up this effect, we performed t-tests comparing SIR scores, for each symptom category, between males and females. Tests were adjusted using the Holm-Bonferroni correction method. On average, female students ($Mean = 50.2$, $SD = 29.8$) generally rated symptoms as more important than male students ($Mean = 43.0$, $SD = 29.3$), and this difference was small ($d = 0.25$; 95% CI: [0.21, 0.28], $p < 0.001$). The gender*symptom interaction effect can be explained by the fact that the differences between females and males were greater in some symptoms than others. Differences in SIRs between females and males ranged from $d = 0.39$ (for Feeling like a Failure) to $d = 0.04$ (for Anhedonia).

Table 2 shows the mean differences and standardized mean differences in SIR values for each symptom.

Table 2

Comparison of Subjective Importance Ratings by Gender

<i>Symptom</i>	Males		Females		t-test Results		
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>	<i>Mean Difference</i>	<i>CI</i>	<i>Effect Size (d)</i>
Feeling like a Failure	44.9	31.7	57.4	31.7	12.4	[8.8, 16.0]	0.39
Sad mood	45.7	30.7	57.0	29.8	11.3	[7.9, 14.7]	0.37
Suicidal Thoughts	45.2	35.4	57.5	34.1	12.3	[8.3, 16.2]	0.35

Low Energy	42.8	26.7	49.0	27.8	6.2	[3.1, 9.3]	0.23
Motor Problems	34.1	25.1	39.8	25.8	5.7	[2.8, 8.6]	0.22
Sleep Problems	41.0	27.9	46.9	28.4	5.9	[2.8, 9.1]	0.21
Appetite	37.2	27.1	42.7	29.1	5.6	[2.3, 8.7]	0.20
Concentration	43.6	27.8	38.8	26.5	4.9	[1.8, 8.0]	0.18
Anhedonia	56.8	25.0	57.6	24.8	0.8	[-2.0, 3.6]	0.04
All Symptoms	43.0	29.3	50.2	29.8	7.2	[6.1, 8.4]	0.25

Caption: Table 2 shows subjective importance ratings by symptom and gender. Bolded values represent differences that were statistically significant after applying the Holm-Bonferroni correction.

Subjective Importance Ratings by Age

A main effect of age reflected the fact that older students tended to report higher SIR values. A one-point increase in age was associated with a 2.35-point increase in SIR ($b = 2.35$, $t(1199.38) = 5.84$, $p < 0.001$).

Subjective Importance Ratings by Self-Reported Depressive Symptoms

As mentioned earlier, the HLM with PHQ-9 score represented with a quadratic term provided better fit than a model in which the PHQ-9 score was not transformed. In this model, a significant effect was observed of the squared PHQ-9 score on SIR ($p < 0.001$; Table 1). To follow-up this finding, rather than using visual inspection to separate the regions of the PHQ-9, we applied PHQ-9 scoring guidelines to categorize individuals into one of four categories (Kroenke & Spitzer, 2002): No depression (scores of 0-4), mild depression (5-9), moderate depression (10-14), or severe depression (15 or greater). Pairwise comparisons, adjusted using Tukey's HSD method, indicated that there were three groups. The three groups, listed in order

from highest SIR values to lowest SIR values, were: Group A (Severe depression), Group B (No depression and Moderate depression), and Group C (Mild depression). Figure 2 depicts the SIR ratings for each category.

Figure 2

Subjective Importance Ratings by Depression Level

Caption: Figure 2 shows the estimates of subjective importance ratings by depression level. Error bars represent ± 1 standard error. The labels indicate distinguishable groups. SIR values did not differ significantly among depression levels in the same group, and SIR values did differ significantly among depression levels in different groups.

Discussion

In an effort to understand the subjective importance of individual symptoms of depression, we acquired subjective importance ratings on nine depressive symptoms from 945 Indian adolescents. We found that some symptoms were valued more highly than others; specifically, the highest ratings were provided for anhedonia, sad mood, suicidal ideation, and feeling like a failure. The lowest ratings were provided for psychomotor problems, appetite changes, and concentration problems.

Our findings have some implications for global mental health research. When attempting to assess and treat mental health problems, global mental health researchers often rely on measurement tools and diagnostic classification systems that were initially developed for populations in western countries (Haroz et al., 2017; Kleinman, 1977; Sweetland et al., 2014). In light of this, some scholars have criticized the validity of global mental health studies. As an example, Summerfield (2008) noted: “It is a basic error of validity to assume that because Western mental phenomena can be identified in non-Western settings, they mean the same as they do in the Western world” (p. 336). Indeed, the discussion around measurement of mental health conditions in non-western societies has tended to focus on whether or not certain symptoms mean “the same thing” in one society compared to another society. This approach emphasizes the importance of linguistic, content, conceptual technical, and criterion equivalence (see Sweetland et al., 2014). Such an approach is undoubtedly important, especially in informing international diagnostic and classification systems. However, here, we offer a question that may complement the existing discussion: regardless of whether or not certain symptoms mean “the same thing” across cultures, how much do people in different cultures value these symptoms? It could be argued that even if “little interest or pleasure in doing things” meant something

different to American adolescents than Indian adolescents, resolving this issue may be a priority in both cultures, especially to the extent that individuals in both countries perceive these symptoms as important, impairing, and undesirable. Relatedly, even if “little interest or pleasure in doing things” means the same thing in two cultures, it is possible that the value placed on that symptom varies across the two cultures.

Therefore, we believe that assessing the subjective importance of symptoms—using methods such as those illustrated here—could meaningfully improve the discussion of measurement in global mental health. When assessing the suitability of a measurement cross-culturally, investigators currently examine its psychometric properties (e.g., internal consistency) and its cross-cultural equivalence (Sweetland et al., 2014). We propose that these metrics can and should be complemented with a focus on subjective importance ratings, particularly when the construct of interest is thought to cause distress and impairment. Imagine, for example, a measure of depression that demonstrates strong psychometric properties, but for which individuals rate each item as unimportant and un concerning. We suggest that such a measure would be less appropriate than a measure that demonstrates both strong psychometric properties and yields high subjective importance ratings. There are two lines of argument supporting this claim. First, insofar as investigators are concerned about helping individuals with problems that they consider to be important, high SIR values are important in their own right. In other words, a treatment that helps people address problems that they did not care about may be considered less useful than a treatment that helps people address problems that they found highly concerning. Second, assuming that the construct of interest (e.g., depression) is thought to be distressing and impairing, the SIR of a measurement can be considered a component of construct validity. That is, if a measure of depression yields low SIR values, investigators have reason to question the

accuracy of their measurement (or the suitability of the measurement for the particular sample). Future work will be needed to help us determine which SIR values should be considered “high” or “low.” For now, a focus on relative SIR values can be informative by showing us which symptoms or conditions are valued “more” or “less” than others. All else equal, symptoms and conditions that receive higher SIR values may be especially useful targets for intervention.

Our findings also contribute to a growing body of literature on the importance of analyzing individual symptoms of depression. Previous work has shown that individual symptoms of depression have different causes and consequences (Fried & Nesse, 2014; Fried et al., 2014), and some symptoms are more central (i.e., more strongly connected to each other) in network analyses (see Beard et al., 2016; Fried et al., 2016; Wasil, Venturo-Conerly, et al., 2020). The subjective importance rating approach adds another dimension to this conversation about different depressive symptoms insofar as some symptoms are considered more important, impairing, and undesirable than others. As research on the differences between individuals symptoms of depression grows, we hope that subjective importance ratings complement other kinds of symptom-level analyses.

We observed individual differences in subjective importance ratings. First, female students provided higher ratings than male students, and these differences were largest for *feeling like a failure*, *sad mood*, and *suicidal thoughts*. Although future research will be needed to determine whether this gender effect replicates, there are a few plausible explanations. First, depression is more common in female adolescents than male adolescents (see Nolen-Hoeksema & Girgus, 1994; Nolen-Hoeksema & Hilt, 2009). As a result, female adolescents may be more attuned to the distressing and impairing consequences of depressive symptoms. Second, females engage in more conversations that involve emotional self-disclosure than males (e.g.,

Valkenburg et al., 2010). Thus, in addition to being more likely to have experienced depressive symptoms themselves, females may also be more likely to have heard about the distressing and impairing impact of depressive symptoms from their peers and friends.

Furthermore, older students tended to provide higher SIR ratings than younger students. It is possible that knowledge about mental illnesses changes as adolescents become older. Previous research has shown that there are clear gaps in adolescents' knowledge about mental illnesses (Wahl, 2012). These gaps in knowledge may diminish with age. Older adolescents have had more time to learn about mental illnesses, either formally (e.g., through coursework or awareness campaigns) or informally (e.g., through personal experiences or the experiences of their friends). Furthermore, a recent study of Indian adolescents showed that older adolescents tended to express less stigma to individuals with mental illnesses (Wasil, Park, & DeRubeis, 2020). It is possible that as stigma toward individuals with mental illness declines, subjective valuations of the importance of mental illnesses rises.

Finally, participants with mild depressive symptoms provided the lowest SIR values, followed by participants with no depression and participants with moderate depression, and participants with severe depression provided the highest ratings. This was unexpected. One possible explanation is that individuals with very few depressive symptoms ("no depression") imagine what it may be like to experience such symptoms, providing relatively high ratings. Meanwhile, individuals with mild depressive symptoms have more direct experience with such symptoms, but may find them to be manageable in their milder form. In contrast, individuals with moderate and severe levels of depressive symptoms may find these highly distressing and impairing symptoms in their more severe form. This would explain the non-monotonic relationship we observed, in which individuals with mild symptoms provided the lowest SIR

values. Nonetheless, these explanations are meant to be hypothesis-generating rather than conclusive, and future research will be needed to replicate and explain these individual differences.

An understanding of the subjective importance of symptoms could be applied to inform treatment outcome research and clinical practice. First, to the extent that clinicians and researchers are able to prioritize the treatment of some symptoms and concerns, subjective importance ratings could inform efforts to prioritize those with the highest ratings. This approach is common in youth mental health treatment, as clinicians and researchers often attempt to identify the problems that are most concerning to youths and their caregivers (Weisz et al., 2011; Wasil et al., 2021). Second, to the extent that treatment outcome researchers are interested in designing treatments that help individuals with the concerns that they find most important, subjective importance ratings could inform treatment evaluation. That is, “importance-adjusted analyses”—in which symptom changes are weighted by a set of subjective importance values—could augment treatment evaluation efforts. In the extreme, it is possible that two treatments could be equally efficacious when applying unweighted analyses, but one of these treatments may lead to greater improvements in symptoms that are highly valued. Some previous research suggests that different treatments have different effects on individual depressive symptoms. For example, meta-analytic data suggest that antidepressant medications and cognitive therapy affect different symptoms, with some symptoms responding more to medications and other responding more to cognitive therapy (Kappelmann et al., 2020). In these situations, where two treatments differ their impact on individual symptoms, subjective importance ratings could be especially useful.

Our findings should be interpreted in light of our study's strengths and limitations. Strengths include a large sample, inclusion of adolescents from a non-western context, and the use of a symptom measure that has been commonly used around the world (Kroenke, 2021), including in India (Shinde et al., 2018; Wasil et al., 2021). One limitation is that we only measured a subset of depressive symptoms (those assessed by the PHQ-9). The PHQ-9 items correspond to the DSM-5 criteria for depression, making the PHQ-9 especially well-suited for an assessment of western diagnostic criteria cross-culturally. However, future research could examine SIR values of locally-derived scales or compare SIR values between different scales for the same construct. Another limitation is that our study involved a sample from the general population; future research is needed to understand SIR values among individuals receiving treatment.

Our findings also suggest several directions for future research. First, future research could understand how people form SIR judgments (e.g., via cognitive interviewing techniques; Beatty & Willis, 2007). Second, future research could extend the SIR approach to additional samples, such as adults, individuals in different countries, and psychiatric patients. The SIR approach could also be used to compare importance ratings between different stakeholders (e.g., children and parents; patients and clinicians) and individuals from different cultures (e.g., Indian adolescents and American adolescents). Third, future research could compare ratings across a broader array of depressive symptoms. Fourth, SIR ratings could be used to compare symptoms across disorders (e.g., depressive symptoms vs. anxiety symptoms). The SIR approach could even be used to compare the subjective importance of symptoms of mental illnesses to those of physical illnesses. Fifth, future work will be needed to understand how to interpret the magnitude

of SIR values. Finally, future research could expand on the SIR approach and explore additional ways to solicit ratings of the subjective importance of different symptoms.

In summary, we have proposed that different symptoms of depression are not valued equally. This notion has important implications for the way we conceptualize psychopathology. Rather than viewing depression as a condition with multiple equally important indicators, it is important to acknowledge that the distinct symptoms appear to differ in their subjective importance. In other words, some symptoms may cause greater distress and impairment than others, and the SIR approach is one way to ascertain which symptoms are thought to cause more suffering. This approach could complement existing ways to understand the differential impact of individual depressive symptoms (Fried & Nesse, 2014). Such an approach differs vastly from typical assumptions in clinical psychological science, which is generally based on the idea that individual depressive symptoms are equally important (i.e., receive equal weights). We have demonstrated that this is not the case, at least when using the SIR approach in a sample of Indian adolescents. We have further proposed that this approach could be useful for global mental health researchers, especially those who wish to validate and use measures that tap into problems that are considered important by the target audience. Indeed, debates about the cross-cultural relevance of western diagnostic systems (Sweetland et al., 2014) can be informed by the degree to which individuals in non-western cultures judge symptoms as important, concerning, and impairing. Of course, the data from this study cannot provide conclusive or universal answers. Future empirical work using the SIR method, or other methods that yield judgments of the relative importance of different symptoms, is needed in both western and non-western contexts. It is our hope that such work accompanies a shift in the way in which we think about depression,

in which the subjective experiences of patients are used to inform clinical science and practice globally.

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