

# **Research Project Portfolio**

University of Nottingham  
School of Medicine

**Doctorate in Clinical Psychology  
2024**

**Adolescents' Conceptualisations of Depression and Recovery:  
A Discourse Analysis**

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Submitted in part fulfilment of the requirements for the  
**Doctorate in Clinical Psychology**

## **Acknowledgements**

I would like to thank my supervisors for their guidance and support throughout this project from start to finish. I would particularly like to thank Dr Anna Tickle for keeping me on track and (mostly) out of all the tempting rabbit holes.

Thank you to everyone who took part in the research interviews. It was a pleasure talking to all of you, and I would like to thank you for being so open about your experiences.

I would also like to thank all my family and friends for being understanding of my absence over the past three years (especially the past few months) and for your unconditional love and support. Particular thanks to my mum and dad for always encouraging my determination and always being on the end of the phone (not to mention everything else you've done to help me get here).

A massive thank you to Millie, Rhian, Laura, and Emma, for your endless encouragement and support throughout the whole of this doctorate. You have made all the hard work of the past three years so much easier to endure (even enjoy at times?!). I feel so lucky to have shared the experience of the thesis rollercoaster with you all, and so grateful for always being able to rely on you for a laugh when I needed it most. I'm thankful that I have made such good friends through this whole experience, and I can't wait to celebrate together in Popworld.

Also, to Sophie, I don't think I have enough words left in me for the amount I would like to thank you. Thank you for blazing the trail for us, and for being a constant source of support in my life over the past few years. I really would not have got this far without knowing you were always there, but I look forward to the day that the doctorate isn't the third member of our friendship.

Finally, I would like to thank Jack for everything. Thank you for keeping my feet on the ground and my diet balanced, and for riding the rollercoaster of emotions by my side. I will always feel so grateful that you knew you wanted to spend your life with me, even when I was in the depths of the thesis hole.

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Total portfolio word count (excluding tables, references, and appendices):  
39,820/45,000

## Portfolio Abstract

Depression is most often first diagnosed during adolescence. Diagnosis rates of depression in adolescents have increased in recent years, in the context of sociocultural changes. Adolescents appear to conceptualise depression and recovery differently to mental health services, and their narratives are therefore marginalised. Adolescents' position within social hierarchies mean they lack power to challenge the marginalisation of their narratives. The way in which depression and recovery are conceptualised have implications for the support that is offered. Conceptualisations of depression and recovery have changed throughout time and within different sociocultural contexts, suggesting that the concepts of depression and recovery are socially constructed. This contrasts with the dominant discourses drawn upon by mental health services, which often endorse the idea that depression is a mental illness resulting from underlying biological dysfunctions, and recovery is the absence of symptoms. This study was underpinned by a social constructionist epistemological stance. It aimed to analyse the discourses drawn upon by both adolescents and widely accessed websites, to conceptualise depression and recovery. Incorporating adolescents' conceptualisations into support that is offered could reduce the power imbalance between adolescents and mental health services.

Participants were recruited through charities for children and young people's mental health, and social media. Semi-structured interviews were completed with 12 adolescents who identified themselves as experiencing depression to explore the discourses that they drew upon in their conceptualisations of depression and recovery. Widely accessed websites for comparative analysis were identified from a Google search and participants' suggestions, and ten were analysed. A combined discourse analysis approach was used, informed by principles of discursive psychology and Foucauldian discourse analysis, to analyse data from interviews and websites.

Adolescents drew upon four primary discourses to conceptualise depression and recovery: Medical discourse assumed but doubted; Disempowerment through relationships; Physical embodiment is a marginalised narrative; From dismissed child to responsible adult. Two further discourses were used by

adolescents to conceptualise the disempowerment they experienced within relationships that related to depression and recovery: Positioned as different and From isolation to connection.

The results suggest that adolescents' use of medical language does not represent their acceptance of psychiatric principles of depression and recovery. Participants instead favoured the alternative discourses they drew upon. Adolescents are dismissed by services when they use their own language to conceptualise depression and they therefore rely on medical language to communicate their experiences. This has been assumed to reflect their experiences as medical ones, which the results of this study throw caution to. Adolescents are disempowered throughout their experiences of depression, and recovery represented an increase in responsibility for them, reflecting the transition to adulthood. Disempowerment may therefore contribute to adolescents' experiences of depression. Adolescents, caregivers, schools, should attend to adolescents' conceptualisations of depression to reduce the power imbalance between adolescents and mental health services.



### **Statement of Contribution**

I, Megan Dixon, declare that this research is the product of my own work designed, conducted, and written as part of the Trent Doctorate in Clinical Psychology training programme. The research was developed in consultation with my research supervisors Dr Anna Tickle, Dr Faye Devlin, and latter supervisory input from Dr Rohan Naidoo. I have received regular guidance from all supervisors with all aspects of the research. I have been the sole researcher for this project, responsible for obtaining ethical approval, the collection and analysis of data and the writing up of the report, supported with feedback and supervision from supervisors.

## **JOURNAL PAPER**

**Title: Adolescents' Conceptualisations of Depression and Recovery: A  
Discourse Analysis**

Short title: Adolescents: Depression and Recovery

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**Word Count:** 4,998/5,000 (excluding abstract, reference list, tables and figures)

Prepared for submission to Psychology and Psychotherapy: Theory Research and Practice. Author guidelines:

<https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448341/homepage/forauthors.html>

## **Adolescents' Conceptualisations of Depression and Recovery: A Discourse Analysis**

### **Abstract**

**Objectives:** Diagnosis rates of depression in adolescents have increased in recent years, in the context of sociocultural changes. Adolescents lack social power and appear to conceptualise depression and recovery differently to mental health services, and their narratives are therefore marginalised. Conceptualisations of depression and recovery have implications for the support that is offered. This study aimed to analyse the discourses drawn upon by both adolescents and widely accessed websites, to conceptualise depression and recovery. Incorporating adolescents' conceptualisations into support that is offered could reduce the power imbalance between adolescents and mental health services. **Design:** This study was underpinned by a social constructionist epistemological stance, using qualitative methodology.

**Methods:** Semi-structured interviews were completed with 12 adolescents who identified themselves as experiencing depression to explore their conceptualisations of depression and recovery. Ten widely accessed websites about depression were identified for comparative analysis. Discourse analysis was used, informed by principles of discursive psychology and Foucauldian discourse analysis. **Results:** Four primary discourses were drawn upon by adolescents to conceptualise depression and recovery: Medical discourse assumed but doubted; Disempowerment through relationships; Physical embodiment is a marginalised narrative; From dismissed child to responsible adult. **Conclusions:** Medical language was used by adolescents, but principles of the medical model were doubted, and alternative discourses favoured. Whilst recovery represented an increased sense of responsibility for adolescents, they are disempowered throughout their experiences of depression. Adolescents, caregivers, schools, should attend to adolescents' conceptualisations of depression to reduce the power imbalance between adolescents and mental health services.

**Keywords:** depression, recovery, discourse analysis, adolescents, mental health

### **Data availability statement**

The data that support the findings of this study are available from the corresponding author upon reasonable request.

### **Acknowledgements**

This project received no specific grant from any funding agency, commercial or not-for-profit sectors. The authors declare no conflicts of interest. The authors would like to thank all participants for taking part in the research.

### **Practitioner points**

- Adolescents appear to conceptualise depression and recovery differently to the dominant medical conceptualisations that are held by mental health services and influence the support that is offered to adolescents. Adolescents' position in society means that they lack power to change this support when their needs are not met.
- Adolescents' use of medical language to conceptualise depression and recovery did not reflect their acceptance of medical conceptualisations. Instead, participants drew upon discourses relating to feeling disempowered in relationships, physical embodiment, and experiences reflecting the transition to adulthood, with an increased sense of responsibility reflective of recovery.
- Adolescents' use of medical language should not be assumed to reflect their medical conceptualisations of depression and recovery. Adolescents' discourses should therefore be prioritised by caregivers, schools, and mental health services, to empower them to access the support that they need. Training in relational skills for schools and caregivers could help adolescents feel empowered in their relationships, therefore preventing experiences of isolation and depression.

## Introduction

Adolescence (ages 10 to 19 years; World Health Organisation [WHO], 2019a), is a unique stage of development comprising of rapid biological, psychological, sexual, and social changes in the transition into adulthood<sup>1</sup> (Blakemore, 2019; Christie & Viner, 2005). These changes can increase individuals' likelihood of being diagnosed with a mental health (MH) problem, most of which, including depression, are first diagnosed during adolescence (Breslau et al., 2017; Jones, 2013). Recent sociocultural changes, such as the COVID-19 pandemic and continued development of social media platforms, have altered adolescents' environments<sup>2</sup>. The Institute of Health Metrics and Evaluation (2019) reported that 1.95% of adolescents were diagnosed with depression, but Racine et al. (2021) indicated that this has risen to 25% since the COVID-19 pandemic. However, a causal link between sociocultural changes and increased rates of depression diagnoses in adolescents has not been established (Nesi, 2020). These estimates may not accurately reflect adolescents' experiences, as their conceptualisations of depression can differ from psychiatric diagnoses (Midgley et al., 2015). Therefore, whilst depression can be viewed as a diagnosable MH problem, the researchers take a critical stance towards the concept of depression, instead viewing it as a social construct.

Depression is among the most diagnosed MH problem within adolescence (National Health Service Digital, 2021), is listed as a leading cause of disability for this age group (WHO, 2021), and reportedly increases their risk of suicidality (Orri et al., 2020). Research suggests that experiencing depression during adolescence can disrupt developmental processes (Clayborne et al., 2019), peer relationships (Lewinsohn et al., 2003) and academic engagement (Nagar et al., 2010). Johnson et al. (2018) also reported long-term consequences, with higher risk of receiving a depression diagnosis later in life, posing further psychosocial consequences (Rahman et al., 2008). WHO (2021) and Patel

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<sup>1</sup> See extended introduction 1.2

<sup>2</sup> See extended introduction 1.5

(2013) therefore argue that effectively managing adolescent depression could address a leading cause of illness in both adolescence and adulthood.

Depressive episodes have historically been seen as a normal feature of adolescence (Erikson, 1950)<sup>3</sup>. Having changed over time, conceptualisations of depression during adolescence are situated within sociocultural contexts (Martin & Atkinson, 2018). Diagnostic categories have, however, become understood as factual, despite little evidence of the underlying biological mechanisms suggested<sup>4</sup> (Ferrari & Villa, 2017). Psychiatric definitions of depression generally include a sad or empty mood (or irritability in adolescents), and cognitive and somatic changes that significantly impact functioning (American Psychiatric Association [APA], 2022; WHO, 2019b). Diagnostic definitions are therefore key in creating and sustaining the medical discourse of depression. Discourse refers to how language constructs and maintains 'knowledge' of the world, suggesting that there is not a single truth of any concept (Gergen, 1985). Alternative understandings of depression therefore also exist, for example from sociological (e.g., Gilbert, 1992) or psychological (e.g., Beck et al., 1979) perspectives<sup>5</sup>. Whilst adolescents' understandings of depression do not appear to align with medical ones, previous research exploring their views is often framed medically.

A meta-synthesis of adolescents' views of depression defined a theme of 'beyond the blues', whereby their experiences transcended psychiatric definitions (Dundon, 2006). Adolescents described isolation (Dundon, 2006; Watson et al., 2020), anger (Dundon, 2006), 'grumpy' moods and feeling misery in their bodies (Midgley et al., 2015), attributing these to relational difficulties within the transition to adulthood (Dundon, 2006). A meta-analysis concluded that whilst young people viewed depression similarly to adults, their understandings were "incomplete" (Georgakakou-Koutsonikou & Williams, 2017), implying that adults' conceptualisations of depression are correct and

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<sup>3</sup> See extended introduction 1.2

<sup>4</sup> See extended introduction 1.6

<sup>5</sup> See extended introduction 1.7

complete. Adolescents' narratives are therefore present, albeit frequently dismissed, within literature often from a different sociocultural time. For instance, Bear et al. (2021) framed young people's experiences of depression within the cognitive model of illness representation, limiting findings to this particular discourse. It therefore appears that adolescents' discourses of their own experiences of depression are being marginalised within the literature (Dunn & Neumann, 2016).

Conceptualisations of depression give rise to corresponding understandings of recovery and appropriate interventions<sup>6</sup>. The medical model, for example, assumes a biochemical cause of depression, and therefore medication is the assumed intervention, with recovery seen as relief from symptoms (Frank et al., 1991). As literature indicates that adolescents conceptualise depression differently to dominant discourses, it is likely that their understandings of recovery also differ. Previous research has identified various effective interventions leading to adolescents' recovery from depression, but recovery was defined medically (Curry et al., 2011). This limits understandings of recovery to the medical model, despite effectiveness of non-medical interventions. Leamy et al. (2011) identified five key processes of recovery through a systematic review, creating a conceptual framework termed 'CHIME', but no papers relating to adolescents were identified. Simonds et al. (2014) found that adolescents conceptualised recovery as developing new meanings of their experiences, changes in identity, reduced social isolation, and feeling hopeful and responsible.

Adolescents have reported feeling misunderstood or dismissed by MH services (MHS), leading them to refuse the care offered (MacDonald et al., 2021). Conversely, they reported that being involved in decisions about their care has enhanced recovery and their sense of agency (Department of Health and Social Care, 2013). Adolescents' structural position within society means that they must do more than adults to assert power over certain situations

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<sup>6</sup> See extended introduction 1.10 and 1.11



(Punch, 2007)<sup>7</sup>, so they arguably lack power to improve access to, or quality of, their MH support (Stige et al., 2021). Adolescents' conceptualisations of depression therefore appear to be marginalised by both literature and MHS, reinforcing dominant discourses. Understanding how they conceptualise depression and recovery may play a key role in reducing the power imbalance in service delivery. This may increase their opportunities to recover by improving their access to, and experiences of, MH care.

### **Rationale and aims<sup>8</sup>**

The purpose of the study was to explore how adolescents conceptualise depression and recovery, considering recent sociocultural changes and within the context of dominant discourses. The study aimed to inform MH professionals' understanding of how adolescents are currently conceptualising depression and recovery. The results of this new knowledge are anticipated to contribute a starting point to the development of appropriate models for assessment, formulation, and intervention for adolescents experiencing depression.

The research questions are:

1. How do adolescents conceptualise depression and recovery?
2. How are depression and recovery conceptualised on websites widely accessed by adolescents?
3. How do adolescents' and websites' conceptualisations compare?

### **Method<sup>9</sup>**

#### **Design**

Epistemologically, this research took a social constructionist perspective<sup>10</sup>, where it is assumed that there are many versions of reality, which are constructed and maintained through social processes including language

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<sup>7</sup> See extended introduction 1.3

<sup>8</sup> See extended introduction 1.12

<sup>9</sup> See extended method 2

<sup>10</sup> See extended method 2.1

(Gergen, 1985). Discourse Analysis (DA) was therefore considered to be the most appropriate method of analysis<sup>11</sup>. Interviews were conducted with adolescents who identified themselves as experiencing depression. Websites explaining depression to adolescents or parents were also analysed.

### **Procedure**

The study received ethical approval from the University of Nottingham (ref-2992)<sup>12</sup>. Participants were recruited via social media and children and young people's MH charities, who posted a recruitment advert on their platforms. The recruitment procedure varied according to participant age<sup>13</sup>, considering the parental consent required for participants under the age of 16, in line with research guidelines (Shaw et al., 2011).

The interview schedule was developed and refined by the primary researcher and was semi-structured to allow space for adolescents' own discourses<sup>14</sup>. Three interviews were completed over video call; six via voice call; and three via the Microsoft Teams chat function (at participants' request). One video call was finished via email. Interviews lasted between 45 minutes and 135 minutes (mean 78 minutes). Participants received a £10 voucher for an online retailer as thanks for their time. Verbal interviews were audio-recorded and transcribed verbatim with linguistic and paralinguistic features in accordance with the Jefferson-lite style of transcription (Potter & Hepburn, 2005). Pseudonyms were used to protect participants' identities, and any identifiable information was removed from transcripts.

Data were collected from websites that appeared on the first page of a Google search of "what is depression - teenager" or participants reported

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<sup>11</sup> See extended method 2.2

<sup>12</sup> See extended method 2.3

<sup>13</sup> See extended method 2.5

<sup>14</sup> See extended method 2.7

accessing<sup>15</sup>. Nine websites were identified to be relevant to the study from Google, and one additional website was suggested by participants.

### **Analytic Approach<sup>16</sup>**

Data were analysed using a mixed DA approach (Wetherell, 1998), combining the methods of discursive psychology (DP; Potter & Wetherell, 1987) and Foucauldian DA (FDA; Willig, 2008). DP focusses on the use of language to achieve interpersonal goals (Potter & Wetherell, 1987). FDA extends this focus, locating conversation within wider discourses which offer and limit ways of talking and opportunities for action, thus viewing power relations as playing a key role (Willig, 2008). A combined approach to DA enabled analysis to acknowledge both the local interview or website discourse, and the discourses and actions available to adolescents and organisations responsible for the websites, also considering the role of power in adolescents' social environments. Analysis was guided by Willig (2008), combining steps for both DP and FDA (see Table 1).

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<sup>15</sup> See extended method 2.6

<sup>16</sup> See extended method 2.8

**Table 1**

*Stages of combined Discursive Psychology and Foucauldian Discourse Analysis (Willig, 2008)*

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Stage of Analysis	Description of the process
Familiarisation with Data	Data was read through twice before analysis was attempted, to enable the researcher to experience the discursive effects of the text as a reader, which were noted.
Coding	Transcripts and webpages were then coded, where passages relevant to the conceptualisations of depression and recovery, whether implicit or explicit, were selected.
Discursive Analysis	Data was analysed with a DP lens, focussing on the linguistic features of the text to ascertain how the discursive objects of depression and recovery are constructed, dependent on context. Particular attention was paid to the use of interpretative repertoires and other discursive devices.
Discourses	The discursive constructions of depression and recovery were located within wider social discourses.
Action Orientation	Attention was paid to the function of constructing depression and recovery in this way, and what is gained from it, allowing a clearer understanding of what the various constructions are capable of achieving within the text.
Positionings	Attention was paid to how the discourses construct the subjects and the positions these place people (self and others) in.
Practice	Analysis of how the constructions used open up or close down opportunities for action for the individual.
Subjectivity	The relationship between discourse and subjectivity was explored, tracing the consequences of positions for the individuals' subjective experience, such as feelings and thoughts.

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## **Results<sup>17</sup>**

Twelve participants, aged between 13 and 17, took part in interviews. Nine participants identified as female, one male and two non-binary. The analysis indicated four primary discourses drawn upon by adolescents in their conceptualisations of depression and recovery. Website data is explored in relation to these discourses.

### **Overview of website data**

Discourses did not appear to differ between websites aimed at caregivers and those aimed at adolescents. Medical narratives were used throughout. Psychological explanations for behaviours were sometimes used, but a diagnosis of depression was often used to explain experiences, in line with psychiatric conceptualisations. Adolescents were always assumed to need support for recovery to happen. Despite use of medical language, drawbacks of medical approaches were highlighted, and psychological approaches were mostly assumed as the primary form of support. Similarities between experiences of depression and of being a teenager were present, whether explicitly stated, or implied. The importance of empowering adolescents was emphasised, advising caregivers to acknowledge their perspectives even if they disagree. However, the language used sometimes contrasted with this, describing behaviours as “problematic” or “deviant”. Some websites encouraged caregivers to also look after themselves, acknowledging the systemic impact of adolescent depression.

### **Medical discourse assumed but doubted**

Medical discourses were assumed as the dominant narrative within most participants’ and websites’ language. Depression was often referred to as “it” throughout interviews, insinuating its objective properties, like other medical illnesses. Whilst medical language was used, participants often did not align with this perspective:

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<sup>17</sup> See extended results 3

I know that [the cause of depression] ... just like (.) a chemical thing in your brain (.) um (.) but (2.5) trying to figure out what (.) caused it (.) was quite hard for me? cuz like (2.5) I didn't feel like there was anything that (0.5) was in my life that was that bad? ... I ↑think .hh a lot of it was just like not being able to (.) go outside? and do the things I enjoyed? (Sophie, p. 17)

Sophie initially assumes a medical understanding of depression, although minimises it with use of the word “just”. She takes a long pause, indicating ‘trouble’ in the conversation (Jefferson, 1989), following which she appears to marginalise the medical model in favour of alternative explanations relating to the covid-19 lockdown. This could suggest that whilst Sophie holds an alternative narrative, she has become aware of the dominant narrative and has felt she must adopt this viewpoint. The dominant medical model therefore seems to limit Sophie’s viewpoints of depression, even when she has alternative experiences, she is not able to openly use these explanations. Sinead (p. 15), however, explicitly casts her doubts on the medical model: “I’m not sure if we can really put down a whole pattern of behaviour... to someone’s chemical imbalance”, although she keeps this tentative, and personal with use of first-person pronouns. Conversely, Millie (p. 2) searched for validation from the medical model “I used to do all these online quizzes... I wanted the screen to tell me I’m depressed and need help and I wanted therapy”. Whilst Millie recognises that she is experiencing some difficulty, this does not feel valid for her without a dominant, medical label and intervention. On the other hand, Riya (p. 2) is dismissive of the medically driven support she received from MHS: “why don’t you help me manage it rather than (.) °give me° drugs?”, instead favouring a psychological understanding of recovery. Websites mostly reject the use of medical treatment options, with Helpguide listing the “red flags” of adolescents’ use of antidepressants, contrasting with Riya’s experience of support offered.

Medical language related to “treatment” was used in all websites apart from Childline, but psychological narratives were favoured when describing causes of

and, support for, depression: “if your child already is in treatment but it isn’t helping, ask them why they think that is. What isn’t helpful or what don’t they like about therapy?...” (Child Mind Institute). This therefore mostly reflects participants’ narratives whereby medical discourses are part of everyday language, but medical principles are rejected in favour of alternative explanations.

### **Disempowerment through relationships**

Relational discourses were drawn upon by all participants to conceptualise their experiences of depression and markers of recovery. Relational processes were identified as playing a key role:

obviously you're not born with anxiety and depression ... I would say it's almost a man-made condition people make people feel a certain way, people say things to people which make them feel a certain way, people do things to make them (.) depressed but that's a whole debate in itself u:::m (.) (Riya, p. 3)

Here, Riya oscillates between presenting a fact (“obviously”), marginalising the medical discourse, and an opinion (“I would say”), protecting herself from accountability. Riya has also used the discursive strategy of a three-part list (Jefferson, 1990) based on social processes, to emphasise her argument. Riya positions individuals experiencing depression as lacking social power to prevent these social processes from happening and impacting them.

### ***Positioned as different***

Feeling different to, or outcast from, others was identified as a key experience of depression:

Interviewer: in what way do you think [neurodiversity diagnosis] impacts ... depression?

Fraser: u:m it's just because ... I thought it was normal then to be told tha:::t and so I'm not gonna be normal for the rest of my life and some opportunities that I had before (.) I won't be able to achieve anymore ... and also ... I have a high possibility of being

discriminated for the rest of my life (.) and and because of that I thought there was no (.) point of living anymore (Fraser, p. 10)

Fraser positions himself within an assumed social hierarchy, whereby others hold the power. Fraser's experiences have not changed, yet he has adopted others' discourses, which confirm his position within the hierarchy, leading to him experience depression. Fraser states that prior to this diagnosis he felt normal, raising the question of whether without others' use of power, he would have experienced depression because of feeling different. He appears to lack power to challenge how he is positioned by others, suggesting that this is pre-prescribed by social processes. Due to the lifelong impact that Fraser feels his difficulties will have, he also indicates that he lacks power to bring about recovery from his position.

Websites, overall, did not highlight how being positioned as different may play a role in the experience of depression. However, YoungMinds mentioned the potential role of discrimination, a relational process which assumes that power is held by others. Mayo Clinic emphasised the negative impact of an "unsupportive environment", further reiterating the impact of social environments on adolescents' experiences. This also reflects Fraser's experience of being unable to challenge the position in which society has placed him.

### ***From isolation to connection***

There was a sense of a transition from feeling isolated prior to and during depression to increased social connection in recovery. Sinead (p. 12) described how "feeling abandoned or isolated has usually triggered some kind of depression for me", equating isolation to the act of being abandoned, and therefore positioning herself as powerless. In contrast, Ceara stated that "it made me really isolate myself from others", locating herself as having a more active role in her experience of isolation.

Alice (p. 17) stated that "even when you are like socialising and like having a laugh you still don't feel like you're fully there", describing a social



disconnection even when physically in the presence of friends. Alice uses second person, positioning herself as not alone in this experience (Mildorf, 2012). Sinead (p, 32) describes “↑my coping strategy is honestly just ... being (.) around people who care about me and I care about”, suggesting the role of meaningful and reciprocated connection in her recovery. Sinead’s intonation on “my” suggests that she views this as her personal experience, not a common one.

Some websites mention the role that social isolation plays in depression. Helpguide emphasises the negative impact of social media use, positioning this as a fact and themselves as experts. Helpguide describes face-to-face connection as a “simple act” to reduce depression, inflating the power imbalance between the experts and the website’s audience. In doing so, this marginalises alternative viewpoints that may be held by the audience. YoungMinds used more tentative language, leaving room for alternative viewpoints to be held:

depression tends to thrive on someone being isolated. It can be extremely useful to reach out and talk to someone about what you're feeling (YoungMinds)

### **Physical embodiment is a marginalised narrative**

Somatic discourses were drawn upon to describe experiences of depression and recovery, mostly with the use of metaphors which, discursively, can strengthen an argument (Lakoff & Johnson, 1980). Some participants and websites described physical experiences such as tiredness, but participants emphasised the embodiment of depression:

...you'd feel that like positive-positivity for like 5 minutes and then it would just absorb into this big boulder of depression ... this massive boulder in in your chest that's like it's just heavy and it's there and you can't do anything to get rid of it no matter how hard you try, no matter how much you go to counselling, you do this, you do that, like it's always just (.) there (Laura, p. 9)

Laura's many attempts to feel better suggest a sense of hope, which is quickly dismissed when they do not work, perhaps reflecting a sense of desperation and powerlessness as she tries to feel better, implying that the depression boulder holds the power as it absorbs positivity. This contrasts with Laura's use of extreme case formulation ("always just there"), emphasising her somatic experience (Pomerantz, 1986) and demonstrating a sense of hopelessness. Jodie likens this heaviness to swimming with clothes on, weighing her down, unable to stay above the surface. Emma (p. 10) reiterates this, describing recovery as feeling like "climbing mount Everest", indicating the physical struggle required in recovery. Making changes to move towards recovery has also made participants "lighter" (Charlie, p. 18; Emma, p. 3, p. 8).

Websites do not refer to an embodiment of depression but instead draw upon a cognitive-behavioural narrative, suggesting that adolescents will experience "a noticeable change in their thinking and behaviour" (WebMD) which "can cause ... physical problems" (Mayo Clinic). Physical changes are therefore framed as a consequence of depression rather than the experience of depression itself, thus marginalising adolescents' narratives. Physical activity is, however, indicated as playing a role in recovery "try to find something active that you enjoy ... maybe a 20-minute jog" (The Mix), with no elaboration on how this impacts adolescents' cognitive-behavioural experiences. This may indicate that the cognitive-behavioural narrative is assumed as common sense, further marginalising adolescent's conceptualisations, as the feeling of carrying a boulder is a likely barrier to enjoying jogging.

Cognitive-behavioural discourses were drawn upon by some participants, for example Alice (p. 3) describes how "the more you think about getting up the more that... you think you can't get up like the more like (.) rubbish you fee(h)l (laughter)" which leads her to stay in bed for longer. Alice's laughter at this point demonstrates a semantic opposition in humour, suggesting a contradiction between her ideals and reality (Raskin, 1984). Whilst cognitive-behavioural theory should incorporate physiological experiences, this appears to be overlooked by websites, but prioritised by participants. Therefore, whilst

cognitive-behavioural narratives are sometimes drawn upon within participants' language, the emphasis is different to websites.

### **From dismissed child to responsible adult**

Experiences of depression and recovery reflected a transition from childhood into adulthood, with a sense of change and increased responsibilities. When they first felt that they might be experiencing depression, Charlie implied the role that their parents had in them making sense of their experiences:

we all kind of ignored it cause my parents (.) didn't wanna get it diagnosed and (.) they didn't believe it was anything um they just believed I was (.) reading stuff on the internet and making assumptions so (1.5) the more I ignored it (.) the more I locked myself away (Charlie, p. 1)

Here, Charlie indicates the inherent power imbalance present within a child-parent relationship. Charlie's own understanding of their experiences of depression are dismissed, which they suggest led to them feeling worse, although they do not make this explicit link. Charlie instead diverts to self-blame following a longer pause, indicating 'trouble' in the conversation (Jefferson, 1989). It appears that, due to the power dynamics, this is Charlie's only available action. Likewise, Emma (p. 2) thought her experiences were "completely normal for kids my age", rather than a sign of depression, until "my parents made me go to a doctor". Whilst Emma's experience contrasts to Charlie's, parents' power plays the same role, limiting both of their opportunities to act in the ways that they wish to. Websites highlight the importance of parents listening to their children's perspectives without making assumptions (Helpguide, YoungMinds, WebMD, Child Mind Institute).

Adulthood narratives were drawn upon in conceptualisations of recovery, "honestly for me it took a lot of stepping up to responsibility" (Emma, p. 10). Emma explicitly states her honesty, highlighting that this was a difficult action to take. Sophie (p. 15) explicitly describes that she "↓grew up a lot ... I was like (1.5) oh(h) ... this world that we ↓live in is not the same world that I lived in

when I was (.) litt(h)le”, indicating how her transition to adulthood impacted on her perspectives. This suggests that Sophie’s childhood naivety appeared to protect her from the reality of adulthood, and her experience of depression could be reflective of her grief for her childhood.

Reflecting Emma’s initial feeling that her experiences were “normal”, websites often query the difference between the experience of depression and of being a teenager (“of course, most teens feel unhappy at times”, WebMD), and the role hormonal changes may play (Helpguide, The Mix, WebMD, Mayo Clinic). Websites also refer to “teen depression” (Hepguide, Relate, WebMD, Mayo Clinic), suggesting that depression is experienced differently by adults. Alice (p. 24) reflects this, perceiving that as she gets older and has more responsibilities, experiencing depression will have more problematic consequences: “how am I supposed to like keep a house in or(h)der”. Alice’s laughter could indicate a contradiction between her ideal future and potential reality (Raskin, 1984).

### **Discussion<sup>18</sup>**

The present study aimed to use DA to explore both adolescents’ and widely accessed websites’ conceptualisations of depression and recovery, and comparisons between these. Some findings corroborate previous literature (Dundon, 2006; Simonds et al., 2014). However, other findings of adolescents’ conceptualisations are novel, as DA does not assume that language represents beliefs. These results highlight the importance of those surrounding adolescents to better understand their conceptualisations of depression and recovery, within the context of recent sociocultural changes, and adolescents’ limited access to social power.

Adolescents have previously used language to describe depression that differs to the language used in diagnostic classification systems (e.g., Midgley et al., 2015). Whilst this is reflected in the current study, medical language was

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<sup>18</sup> See extended discussion 4

also used. However, psychiatric principles were largely dismissed by participants and websites, suggesting that medical language has become a part of everyday talk but does not necessarily represent acceptance of the medical model, as structuralist models would assume. Foucault (1969/2002) argued that the concepts which appear most obviously are those which should be questioned. It therefore seems that as MHS adopted medical criteria for access, medical language became assumed and social practices reinforced its use. Adolescents experiencing depression are dismissed by services and literature when they use their own language (e.g., MacDonald et al., 2021; Georgakakou-Koutsonikou & Williams, 2017). Therefore, they rely on medical language to communicate their experiences, which is assumed to reflect their conceptualisations. Since adolescents lack power to change their MH care (Stige et al., 2021), caregivers, schools, and MHS should acknowledge that adolescents' use of medical language does not reflect their experience of depression as a medical one. Arguably, reinforcing this discourse could unintentionally be dismissing, contributing to adolescents' experiences of depression.

Websites positioning face-to-face socialising as "simple" may further dismiss, and contribute to, adolescents' experiences, particularly as more social connection occurs online (Marciano et al., 2022). This may prevent them from seeking support, as they are made to feel more isolated and different. Adolescents have previously highlighted the role of relational difficulties in their experience of depression (Dundon, 2006), including isolation (Watson et al., 2020). Relational difficulties are likely during adolescence as social worlds are reorganised (Blakemore, 2019). Participants used relational discourses, with isolation and feeling different as key experiences of depression. They positioned themselves as lacking social power to change these experiences and prevent the negative impact on them. Whilst social connection is identified as a marker of recovery for those feeling isolated, there are less opportunities for individuals to prevent discrimination and other negative relational processes.

Somatic changes are included in diagnostic criteria for depression but are quantified or must be "observable by others, not merely subjective feelings"

(APA, 2013, p.161). Conversely, participants described somatic experiences which were neither observable nor measurable, in line with previous research (Midgley et al., 2015). Medicalised understandings of depression therefore arguably rely too heavily on observable and measurable phenomenon which not only overly simplifies the experience but potentially dismisses adolescents' narratives. Adolescents experiencing depression in a non-measurable way may therefore not meet criteria to access support. They may therefore be rejected from MHS or rely on medical narratives to be heard, lacking power to challenge dominant perspectives.

Adolescents have previously identified the role of the transition to adulthood in their experiences of depression (Dundon, 2006). Whilst this was reflected by participants in the current study, there was also a sense of maturation from experiencing depression to recovery, from lacking power to gaining responsibility. This sense of responsibility reflects previous findings of adolescents' conceptualisations of recovery (Simonds et al., 2014). Some participants and most websites questioned whether these experiences were ordinary for adolescents, or an experience of depression. This highlights the ongoing controversy surrounding the 'existence' of depression during adolescence. Adolescents' individual perspectives should therefore be prioritised, considering their lack of power and the role of gatekeepers in their access to support.

### **Limitations<sup>19</sup>**

In DA research, naturally occurring data, such as recordings of "real world" conversations, is preferred to interview data (Wodak & Meyer, 2015). Ethical and practical difficulties in collecting such data deemed interview data more appropriate. However, interviewers also construct meaning (Silverman, 2015). To reduce the impact of this, interviews were semi-structured, and language was kept open, to not introduce new discourses. Semi-structured interviews were an appropriate method to answer the research questions (Willig, 2013).

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<sup>19</sup> See extended limitations 4.6

Attempts were made to reduce the power imbalance inherent in research-participant and adult-child relationships (Punch, 2002). Consent was confirmed before interviews, and participants were reminded of their right to withdraw. It was reiterated throughout interviews no answers were 'right' or 'wrong'.

Only having one participant under the age of 16, despite interest from others, is a further limitation. Due to parental consent required, this highlights the potential barrier that gatekeepers present to engagement in research and may reflect processes in adolescents' mental health support-seeking.

It was not possible to recruit individuals to contribute to patient and public involvement (PPI) and involvement was therefore limited throughout the study. Adolescents being involved throughout different stages of the project could have ensured relevance of the study for them. PPI will be prioritised in the dissemination of results.

### **Clinical and research implications<sup>20</sup>**

All discourses drawn upon indicate adolescents' disempowerment in their experiences of depression. MHS, schools, and caregivers, should empower adolescents and reduce marginalisation of their narratives by dominant discourses. This could include adopting less-objective criteria for MHS and ensuring that adolescents' narratives are acknowledged in clinical guidelines, to influence service criteria. For example, criteria could incorporate somatic experiences that adolescents may have, even in the absence of more dominant discourses such as negative cognitions, in line with adolescents' development. Generally, adult pathways and criteria are less flexible than child and adolescent MHS (Lamb & Murphy, 2013). Therefore, this may impact adolescent's access to adult services as they transition. Further research could apply DA to patients' written records to explore MH professionals' use of medical discourses of depression in practice.

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<sup>20</sup> See extended clinical implications 4.7 and extended future research 4.8

Results indicate the potential use for non-medicalised approaches for adolescent experiences of depression, including psychological formulation or social constructionist approaches such as narrative therapy (Freedman & Coombs, 1996). The appropriateness of these approaches should therefore be explored in future research. Although social reorganisation and peer rejection are key experiences of adolescence (Mulvey et al., 2017), encouraging schools and caregivers to listen to adolescents' experiences without judgement could reduce the assumed medicalisation of their experiences. Future research could also explore how equipped schools and caregivers feel to manage these relational processes during adolescence without reliance on medical discourses.

### **Conclusion**

Whilst medical language was used by adolescents in their conceptualisations of depression and recovery, medical principles were doubted. Discourses of relational processes, embodiment, and transitions to adulthood were instead drawn upon, in contrast to the medical discourse that permeates throughout MHS. Adolescents are disempowered throughout their experiences of depression. Recovery was primarily seen as representing an increase in responsibility, in the context of adolescents' transition to adulthood. Adolescents' discourses need to be prioritised, to empower them in both in their experiences of depression and their access to MHS.



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### **Statement of contribution**

This research is the product of work designed, conducted, and written as part of the Doctorate in Clinical Psychology training programme. **Contributions from Megan Dixon:** Research conceptualisation and development; ethical approval; project administration; data collection, data analysis; writing. **Contributions from Dr Anna Tickle:** Research conceptualisations and development; supervision of data collection; supervision of data analysis; review and editing of report. **Contributions from Dr Rohan Naidoo:** Research conceptualisation and development; supervision of data collection; supervision of data analysis. **Contributions from Dr Faye Devlin:** Research conceptualisation and development

## **EXTENDED PAPER**



## 1. Extended introduction

### 1.1 Terminology

The terminology of 'mental illness' or 'mental disorder' has psychiatric connotations, suggesting that an individual has an underlying dysfunction (Horwitz, 2002; see *1.6 medical conceptualisations of depression*). This therefore locates the 'illness' within an individual, disregarding the potential impact of wider systems around an individual (see *1.7 other theoretical conceptualisations of depression*). The term 'recovery' also holds medical connotations and is suggestive of an illness that can be removed (see *1.10 conceptualisations of recovery*). Terminology referring to psychiatric diagnostic categories, including 'depression', can also indicate this. It could therefore be argued that using the terms 'depression' and 'recovery' endorse psychiatric discourses. However, psychiatric discourses of mental illness have filtered into everyday life. The use of the term 'depression' therefore often refers to experiences wider than those that have been diagnosed as a mental illness, and is often used more colloquially (Epstein et al., 2010). It has also been highlighted how the term 'depression' can informally represent such a diverse range of experiences (Epstein et al., 2010). The term 'recovery' has also been used by non-medical perspectives and has been conceptualised differently, such as being a process rather than an event (Jacobson & Greenley, 2001; see *1.10 conceptualisations of recovery*). Therefore, although the use of the terms 'depression' and 'recovery' may continue to perpetuate the medical discourse, there is also a pragmatic argument to use widely understood terminology until more appropriate language is developed.

Whilst the terms 'mental illness' or 'mental disorder' hold medical connotations, those such as 'mental health problems' or 'mental health issues' are often used to cover a broader range of experiences, including those that have not been diagnosed as a mental illness (Seddon, 2006; Rickwood et al., 2005). These terms are therefore used interchangeably throughout the paper, in line with the research being referenced, the theory being discussed, or the statement being made.

## 1.2 Adolescence

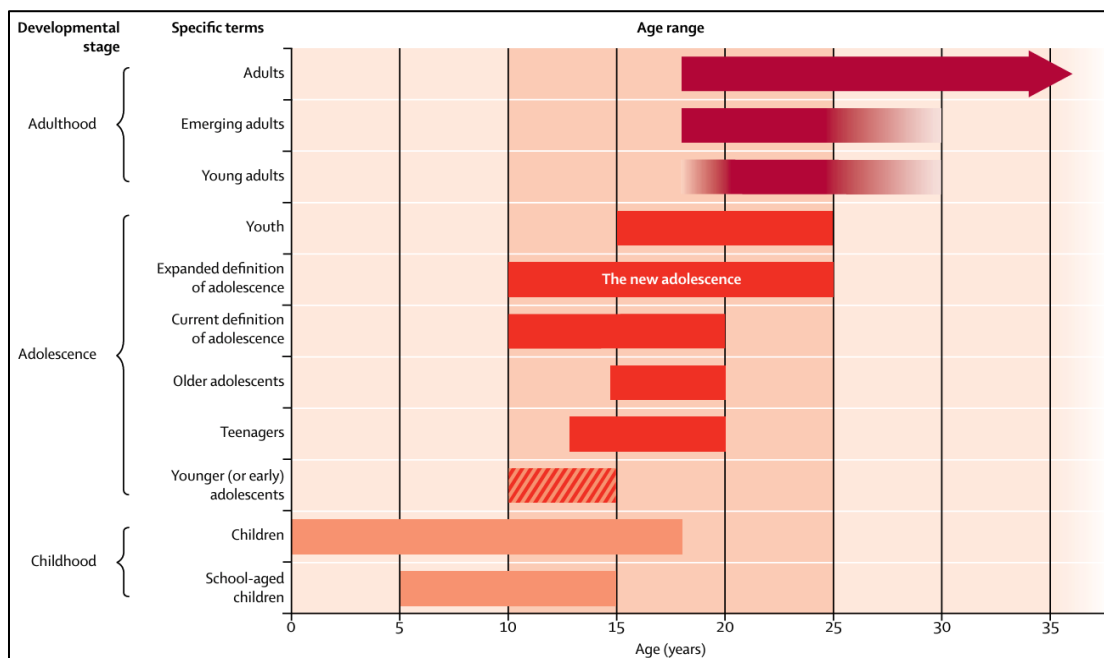
There is ongoing debate about what defines the period of adolescence. Whilst adolescence is generally agreed to commence with puberty, the end point is less defined. It is commonly argued that adolescence ends at the age of independence, but this is socially and culturally dependent (Blakemore, 2019). The age of independence appears to be shifting over time. For example, with education or training being compulsory until the age of 18 rather than 16 in the UK (Education and Skills Act 2008, updated in 2015), adolescents are having to rely on caregivers for longer (Sawyer, 2018). Culturally, therefore, adolescence has arguably shifted in line with these changes, and there are arguments for the change in the definition, up to the age of 24 (Sawyer et al., 2018). Others, however, argue that adolescence should remain the definition for this distinct period of development (Blakemore, 2019). Further to this, however, research has shown that brains continue to develop into the third decade (Simmonds et al., 2014), and there are arguments that this should be considered within the definition of adolescence. The American Academy of Paediatrics has an upper age limit of 21 to maximise healthy development during adolescence (Hardin & Hackell, 2017). Whilst there is therefore not a single definition of adolescence, Sawyer (2018) highlights the overlap in terminology (see Figure 1) and the meanings that different terminology conveys. For example, Sawyer (2018) describes how a 16-year-old could simultaneously be seen as a child, an adolescent, and a youth: “child suggests dependency, youth signals independence, and adolescence captures the notion of the growing individual who is able to take increasing responsibility, but who still needs more protection than an adult” (Sawyer, 2018, p.1). The terminology used is therefore inherently linked with ideas of power available to individuals at these life stages (see 1.3 *adolescents’ social power*).

However it is defined, adolescence nevertheless represents a time of change. Puberty involves a series of hormonal changes which lead to physical changes, such as increased height, onset of menstruation, and ability to reproduce (Wood et al., 2019). Individuals may therefore look, feel, and be treated, more like an adult following puberty (Blakemore, 2019). Brains have also been found to develop substantially throughout adolescence, before

stabilising in the mid-twenties, although brain regions involved in more complex cognitive processes continue to develop past this age (Casey et al., 2008). Whilst, in childhood, excessive numbers of synapses are produced, these are pruned during adolescence, and those which aren't used are eliminated (Spear, 2013). These are mechanisms of neuroplasticity, where brain development is influenced by the environment and it is suggested that this is partly what makes children and adolescents vulnerable to adverse environments (McLaughlin et al., 2019).

**Figure 1**

*Commonly used definitions of age relating to adolescence, taken from Sawyer (2018)*



During adolescence, cognitive abilities also start to improve, which enables individuals to reflect on themselves, their futures, and what others think of them, as outlined by Blakemore (2019):

- Mentalisation skills develop: the ability to understand other people's minds and take other people's perspectives
- Ability to plan
- Ability to inhibit inappropriate behaviour
- Ability to consider the future and delay gratification
- Awareness of the self

These biological, neurological, and cognitive changes throughout adolescence are necessary to become an independent adult. These changes, however, can also affect their world and create new challenges, such as making sense of their identity in relation to the people around them (Blakemore, 2019).

Adolescence is also a time of social reorganisation, as individuals attempt to seek independence and start spending less time with parental figures and more time with peers (Christie & Viner, 2005). As social priorities change, a sense of belonging becomes paramount (Brown & Larson, 2009), and adolescents begin to identify more with peers than with parents (Selvam, 2017). Meeting the innate need for peer connection can significantly decrease the psychological impact of stressful events (Brown & Larson, 2009), such as the transition to adulthood (Mauder & Sibbald, 2011). Peer relationships, however, also become more complex during adolescence, as romantic or intimate relationships begin to be explored, and social hierarchies emerge (Brown et al., 2008).

Erikson's (1950, 1959) seminal developmental theory posits that development happens in stages, during which a crisis or conflict is present. Resolution of the crisis enables successful progression onto the next stage. The crisis of the adolescent age is termed "identity vs confusion". As such, Erikson proposed that exploration of different roles, activities, beliefs, and behaviours occurs through social interaction. Therefore, during adolescence, identity develops as a result of new experiences and information acquired through interaction with others, as social worlds reorganise. Therefore, Erikson postulated that being unable to explore different identities through social interaction will leave an individual with a sense of role confusion. Not successfully resolving this developmental stage, in this sense, can lead to negative consequences for an individual's development. The idea of individuation reflects this, highlighting the importance of adolescents exploring their social identity away from their family and navigating social complexities to influence the development of their identity (Jung, 1969). Unsuccessful

individuation has been associated with mental health problems, including depression (Minev, 2018).

Other theories also place the role of social relationships at the centre of adolescent development. Bronfenbrenner (1992), for example, proposed an ecological systems theory, whereby an individual's development occurs within a complex system of relationships, at multiple levels of their environment. Whilst the most immediate environment (such as family and school) is suggested to be most influential on development, these only exist within wider systemic and societal contexts, such as culture, politics, and social norms. These theories therefore agree that social relationships and their interconnectivity are central to adolescent development, with these ideas highlighting the systemic nature of adolescent mental health. These theories therefore contrast with diagnostic systems, which locate problems within an individual, rather than within interpersonal contexts (see *1.6 medical conceptualisations of depression*).

### **1.3 Adolescents' social power**

French and Raven (1959) distinguish between five types of resource which can give one individual the power to influence another:

- Reward: the resource is the ability to reward
- Coercive: the resource is the ability to punish or threaten punishment
- Referent: if the influenced person identifies with or desires to identify with the individual with power
- Legitimate: person with power is viewed as having the right to exercise power, due to values accepted by the influenced person
- Expert: the resource is useful or improved knowledge

Considering the role of these types of power in adolescents' relationships may be central to understanding experiences and expression of depression. Within social hierarchies, children's power tends to be constrained by adults' regulatory use of their generational power (Brannen et al., 2000). Parents can readily access all the above resources, to exercise power over children (Kandel

& Lesser, 1969; Smith, 1970). However, Secord and Backman (1964) suggest that the ability to use these resources depends on two other conditions. Firstly, the amount that the influenced individual depends on the resource being used and secondly, their access to alternative sources of the resource. Research has identified that adolescents' resistance to parental control is often fostered by peer relationships (e.g., Davis, 1940). Therefore, whilst children tend to lack power in their relationships with adults, parental power tends to wane during adolescence as adolescents begin to access resources from alternative sources. Some research, however, indicates that parents retain some influence over adolescents (outlined in Brown et al., 1993). Power may also be at play in other aspects of adolescents' lives, however, such as from teachers and wider school systems.

#### **1.4 Adolescents' vulnerability to experiencing depression**

Research has indicated that adolescence is a high-risk time for receiving an initial diagnosis of depression (Avenevoli et al., 2015). Adolescence has long been considered a challenging period, with it being defined in the past as a time of " Sturm und Drang" (Hall, 1904). Erikson (1950) too argued that 'symptoms' that may appear to be indicative of mental illness are in fact the "normative crisis" during adolescence that is part of their identity formation. In the 1970s, controversy about this began to arise within the literature, with research searching for evidence that these difficulties observed during adolescence were in fact signs of mental health issues (Rutter et al., 1976). By 1980, adolescent depression was succinctly described in the 3<sup>rd</sup> edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 1980), and as such was defined as a mental illness (see *1.6 medical conceptualisations of depression*). Since this time, various factors have been identified that may increase adolescents' vulnerability to experiencing depression, although no direct causal factors have been identified.

Adverse childhood experiences (ACEs) include early experience of abuse, neglect, and trauma (Centers for Disease Control and Prevention, 2019). The association between ACEs and increased risk of mental health problems in adulthood, such as depression, substance use, and anxiety, has been well-

documented (Felitti et al., 1998; Chapman et al., 2004), but the impact of ACEs on adolescent mental health is less well understood. Research suggests that the long-term consequences of ACEs are due to permanent changes in brain development due to chronic activation of the stress response (Shonkoff et al., 2012). It may therefore be difficult to understand the impact of ACEs on adolescents, due to their ongoing brain development. However, the relational aspects of the trauma that constitute ACEs are also suggested to alter the context of attachment processes, leading to insecure attachment styles (Corcoran & McNulty, 2018). An association between insecure attachment styles and experiences of depression has also been identified (Madigan et al., 2016). Preliminary research has indicated that most types of ACE, apart from economic hardship, are more strongly associated with experiences of depression, rather than anxiety, in adolescence (Elmore & Crouch, 2020). However, these were based on diagnoses of anxiety or depression from doctors. Given the frequency with which adolescents are diagnosed with anxiety and depression simultaneously (Melton et al., 2018), the validity of these results could be questioned.

Social exclusion can include rejection, social isolation, and discrimination (Riva & Eck, 2016) and in the adolescent context is often conceptualised as rejection from a peer group, which can be either passive or active (Reicher & Matischek-Jauk, 2018). A prospective cohort study found that being victimised by peers during early adolescence increased the risk of experiencing depression at the age of 18 (Bowes et al., 2015). Milder forms of social exclusion such as a lack of social support have also been associated with increased risk of being diagnosed with depression (Fung et al., 2016). However, there are arguments that this could be a vicious cycle, considering the negative perceptions that are often experienced during depression (Beck, 2002), which could influence an individuals' perception of poor social support.

### **1.5 Adolescents' mental health and sociocultural changes**

#### ***Social media***

Although a causal link has not been found, a sharp rise in adolescents reporting to experience depression has coincided with advances in technology,

widespread use of the internet, and continued development of social media platforms (Nesi, 2020). Adolescents use the internet at higher rates than any other age group (International Telecommunication Union, 2021), with more than 70% of adolescents exceeding screen time guidelines of less than 2 hours per day in their leisure time (Morley et al., 2012). With rapid developments of social technology, adolescents over the past 5-10 years have arguably been raised with social media and, with that, a novel way of viewing the world and other people. Social media has been suggested to influence adolescents' social, emotional and identity development (O'Keeffe & Clarke-Pearson, 2011), although this lacks empirical evidence.

Research initially suggested that increased use of the internet for social purposes was associated with increased loneliness and symptoms of depression (Kraut et al., 1998). More specifically, recreational screen time has been negatively associated with adolescent psychological wellbeing, whilst the same association was not found for non-recreational screen time, such as for homework (Babic et al., 2017). Adolescents have reported that social media can have 'good, bad or ugly' consequences (O'Reilly, 2020), which appears to depend on the ways in which they use it (Hjetland et al., 2021). More recently, parents have identified social media use as facilitative for recovery for adolescents with mental health problems (Kelly & Coughlan, 2019). A recent systematic review, however, concluded that there was a general correlation between adolescents' social media use and mental health problems but that this relationship was complex (Keles et al., 2020). Mediating or moderating variables were identified, such as insomnia, perceived social support, rumination, motivations for social media use, social comparison, and self-esteem (Keles et al., 2020). This review concluded that attitudes or behaviours (motives for social media use, social comparison, active or passive use) may have a larger influence on mental health symptoms than frequency of social media use (Keles et al., 2020). It does seem, however, that social media is important for adolescents to explore their identity in relation to others (Uhls et al., 2017), gain their desired independence from parents, and membership of their peer group (Quinn & Oldmeadow, 2013).



Adolescents have also used the internet to seek information about mental health, as they perceive it as a viable alternative to traditional sources of health information (Gray et al., 2005). Adolescents' online searches about mental health have previously been found to mostly concern depression (Horgan & Sweeney, 2010). Access to online mental health information may therefore arguably satisfy adolescents' desire for autonomy. However, there is increasing awareness of the use of algorithms by social media platforms, such as TikTok. Briefly engaging with depression-related content creates a "rabbit hole" effect, whereby content that encourages depressive or suicidal thinking is increasingly shown (Amnesty International, 2021) at the expense of unrelated content. This therefore suggests that social media algorithms may purposefully reinforce, or strengthen already-held perspectives, limiting access to alternative narratives. Adolescents using social media may therefore be exposed to discourses of depression, even when they are not actively seeking them out, particularly if they have engaged with related content in the past.

### **COVID-19**

In many countries, the COVID-19 pandemic resulted in closures of schools for several months, physical distancing measures, and guidance to stay at home (Király et al., 2020). This therefore altered adolescents' social worlds, with more time spent at home and face-to-face contact with peers often unavailable, contrasting to the usual social priorities at this time. Whilst the COVID-19 pandemic had widespread consequences for individuals, the impact on adolescents is thought to be unique, due to the importance of peer relationships. Adolescents reported friendship changes as their biggest challenge during the pandemic (Scott et al., 2021). Adolescents' use of social media, however, was found to improve their social connectedness throughout the pandemic (Marciano et al., 2022), potentially enabling the development of their identity, independence, and peer group membership to continue despite social restrictions. However, adolescents' increased reported levels of loneliness and depression did not appear to alleviate following time spent with friends online (Ellis et al., 2020). Longitudinal research has also demonstrated that feelings of loneliness predicted worse experiences of depression, although this was a stronger effect for adolescents who reported experiencing depression

prior to the pandemic (Schwartz-Mette et al., 2023). Nevertheless, research surrounding consequences of the COVID-19 pandemic on adolescent experiences of depression indicates the protective factors of social connectedness during adolescence, and the negative effects of loneliness.

### **1.6 Medical conceptualisations of depression**

The medical discourse and its associated institutions have long been criticised by discourse analysts (Foucault, 1963/1973). In the 1950s, tuberculosis medication was seen to be helpful in alleviating individuals' depression-related symptoms, and medication for depression consequently started to be developed. The medical model of mental disorders then began to emerge in the 1970s, viewing mental illnesses through the same lens as physical illnesses. The medical model takes the perspective that all mental illnesses have physiological causes and can be treated with medication. There are many biological factors that are suggested to cause adolescent depression, including the roles of genes (e.g., Xia & Yao, 2015), sleep disorders (Urrila et al., 2015), and serotonin (Xia & Yao, 2015). However, unlike for physical illnesses, these underlying biological mechanisms have not yet been identified (Pariante, 2017). The role that adolescents' environments play in neurodevelopment also suggests that these potential biological mechanisms do not occur in isolation (McLaughlin et al., 2019).

A lack of evidence for biological causes and, consequently a lack of objective tests of mental illnesses, positioned them as inherently different to physical illnesses. There was therefore a medical need to improve communication and agreement about experiences of mental illness between clinicians, and the American Psychiatric Association (APA) therefore developed a third edition of their DSM (DSM-III; APA, 1980). The DSM-III included, for the first time, specific criteria for each diagnostic category to enhance reliability between clinicians. The DSM-III, however, disclaimed that the categories were based on clinicians' judgement and were not validated by research (APA, 1980), inherently differing from other medical illnesses. Therefore, the need for inter-rater reliability is reinforced in order to align with the medical model, further

reinforcing the medical field's perception of need for the DSM itself despite a lack of objectivity.

The DSM-III emphasised that “there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, as well as between it and No Mental Disorder” (APA, 1980, p.6), and describes it as an organisational system that creates common language between professionals. However, a more recent edition of the DSM, the DSM-5 (APA, 2013), then describes the efforts of scientific research to identify the underlying causes of distinct categories, citing efforts to ensure both validity and reliability of diagnostic categories, despite little success in the 30 years since the DSM-III. The psychiatric concept of diagnostic categories has become dominant in mental health settings, scientific research, legal proceedings, and regulatory processes, and continues to assume that certain patterns of behaviour reflect an underlying pathological mechanism. Diagnostic categories have therefore, perhaps unintentionally, become to be seen as real, discoverable disorders, which are unchanging across cultures and times, a process termed ‘reification’. Psychiatry is therefore making an arguably unjustifiable attempt to follow medicine’s conventional processes, needing reliable and widely agreed definitions of disease to understand prognosis, other related impairments, and make rational decisions about appropriate treatments (Hyman, 2010).

Psychiatrists themselves have criticised the diagnostic categories of mental illness. Szasz (1960, 2007) argued that mental illness is a myth and was invented by society to ostracise individuals whose behaviour was deemed to be outside of social norms. Szasz (1960) also argued that the discipline of psychiatry should be concerned with the ‘problems in living’ rather than diseases of the brain. This is reflected more recently, in Timimi’s (2014) statement that diagnostic criteria lack causal evidence, validity, and reliability, arguing that the conclusion, based on evidence, should be to abolish diagnostic systems. Overall, the reliance on subjective judgement, rather than objective tests, for a psychiatric diagnosis, inherently sets them apart from medical illnesses. Nevertheless, criteria for mental health services (MHS) and pathways

of care continue to be based upon these diagnostic categories, with the medical model continuing to be dominant (see *1.11 guidelines and services for adolescents experiencing*).

The inclusion of adolescent-specific features in the diagnostic criteria of major depressive disorder (MDD) by the DSM-III (APA, 1980), changed how psychological difficulties during adolescence were conceptualised. Prior to this, psychological difficulties were seen as an expected part of the adolescent experience (see *1.2 adolescence*). It could be argued that the DSM-III pathologised ordinary adolescent experiences in its definition of adolescent MDD:

In adolescent boys negativistic or frankly antisocial behavior may appear. Feelings of wanting to leave home or of not being understood and approved of, restlessness, grouchiness, and aggression are common. Sulkiness, a reluctance to cooperate in family ventures, and withdrawal from social activities, with retreat to one's room, are frequent. School difficulties are likely. There may be inattention to personal appearance and increased emotionality, with particular sensitivity to rejection in love relationships. Substance Abuse may develop. (APA, 1980, p.211-212)

Striving for independence, reduced time spent with family, and heightened fear of social rejection are fundamental aspects of the adolescent experience (see *1.2 adolescence*) yet are included here as key markers of experiencing MDD. Nevertheless, and despite the ongoing nature of this debate, the commissioning of child and adolescent mental health services (CAMHS) suggests that the medical conceptualisation of adolescent mental illnesses is dominant, at least in Western societies. Further to this, the DSM-III (APA, 1980) also only refers to this experience in boys, despite referring to both girls and boys in the criteria for childhood depression. This is at odds with the current higher diagnostic rates of depression in adolescent girls, compared to boys (Salk et al., 2017; see *1.8 social, cultural and religious conceptualisations of depression*).

The current version of the DSM, the DSM-V-TR (APA, 2022), refers to adolescents' experiences in three definitions of depressive disorders: Disruptive Mood Dysregulation Disorder (DMDD), MDD, and Persistent Depressive Disorder (PDD). DMDD cannot be initially diagnosed prior to the age of 6 or after the age of 18, and the DSM-V-TR states that symptoms should have started before the age of 10. The criteria for DMDD includes "severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviourally... that are grossly out of proportion... to the situation" (APA, 2022, p.81). The DSM-V-TR specifies that these outbursts are inconsistent with developmental level, but further elaboration is not provided. There are no longer specific diagnostic criteria for adolescent MDD, and adolescents must therefore meet criteria for adults to receive a diagnosis, except for potentially experiencing irritable, rather than depressed, mood. Other criteria for MDD are defined as: reduced pleasure in activities; 5% change in body weight (or failure to make expected weight gain in children); insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or energy loss; feelings of worthlessness or excessive guilt; diminished cognitive abilities; recurrent thoughts of death, suicidal ideation, suicide attempts or plans. The DSM-V-TR specifies that an individual must meet five or more of these criteria within a 2-week period. PDD is defined similarly but must have lasted for 2 years for adults, or 1 year for adolescents (APA, 2022). The DSM-V-TR also states that these symptoms should cause clinically significant distress or functional impairment. This criterion may therefore marginalise experiences that are not deemed "bad enough". The International Classification of Diseases, 11<sup>th</sup> Edition (ICD-11; World Health Organisation [WHO], 2019), however, uses a continuum to define depressive disorders, ranging from mild to severe. A mild depressive episode is suggested to occur when an individual only has some difficulties in functioning. The ICD-11 is therefore perhaps more inclusive, diagnostically, to a range of experiences of depression that individuals might have.

Further to this, DMDD, MDD and PDD are not represented within the ICD-11 (WHO, 2019). ICD-11 criteria for depression diagnoses are instead defined as single episode depressive disorder, recurrent depressive disorder, and

dysthymic disorder, with varying levels of severity within each category. To receive a diagnosis of depression in the United Kingdom, an individual must meet the criteria as defined within the International Classification of Diseases, 11<sup>th</sup> Edition (ICD-11; WHO, 2019). The differences between the DSM-V-TR and ICD-11 diagnostic criteria for depression provide critique for psychiatric model of mental illness. If diagnoses are distinct categories with corresponding underlying causes, as defined by the DSM-V (APA, 2013), variation would not be seen between different diagnostic systems. Variations in definitions therefore reflect different 'truths', even within the medical model, of what constitutes depression. This reflects the subjective judgement involved in the creation of diagnostic criteria, as well as in the diagnostic process. Historically, the DSM has been criticised for being developed by work groups comprised of individuals who mostly identified as white and upper- and middle-class (Good, 1996). This has meant that an attempt to create a 'norm' or 'truth' is done in a way that has not acknowledged the variety of truths that exist. New work groups were involved in the development of the DSM-V-TR, however, in an attempt to acknowledge cultural differences within diagnoses (APA, 2022). However, these groups aimed to reduce stigmatising or discriminatory language throughout the DSM, and remained within the context of the medical model, and it is suggested that evidence from non-Western cultures is not treated with the same authority to inform diagnostic criteria (Aggarwal, 2013).

### **1.7 Other theoretical conceptualisations of depression**

Following the publication of the DSM-III, depression became the most diagnosed mental illness, constituting almost 40% of all psychiatric diagnoses (Olfson et al., 2002). However, aside from medical understandings and prior to the publication of the DSM, alternative understandings of depression are, and have been, more widely understood. From a social constructionist perspective, the concept of depression is situated within time and culture. For example, whilst medical perspectives offer one understanding of depression, different theoretical perspectives take a range of views. Whilst the primary critique of the medical model is the lack of evidence to support its assumptions, alternative theories also lack evidence to support their existence. Foucault (1966/1994, 1963/1973) argued that the dominant nature of the medical discourse is due to

its economic, political, and institutional power to construct its version of the world, rather than its ability to offer objective truth. The range of conceptualisations of depression demonstrate the lack of one “truth”, and instead indicate that there are many versions of reality (Gergen, 1985). These different perspectives are likely to influence common understandings of depression, therefore impacting on adolescents’ conceptualisations and researcher interpretations.

### ***The biopsychosocial model***

The biopsychosocial model of mental illness emerged as a result of dissatisfaction with the medical model (Engel, 1977). It is suggested that no psychological experience can be explained by neurobiology alone (Gold, 2009). Engel (1977) instead suggested that biological, psychological, and social contextual factors all interact in the onset of an individual’s mental health problems. The biological, psychological, and social changes that take place during adolescence would deem the biopsychosocial model highly relevant to understand their experiences of depression. However, there is a paucity of research exploring the applicability of this model to adolescents’ experiences of depression, and literature suggests that the model has had little influence on organisation and funding of healthcare in comparison to medical models (Wade & Halligan, 2017).

### ***Psychodynamic conceptualisations***

Historic editions of the DSM categorised the experience of depression as a psychotic disorder, in line with the psychodynamic theory that influenced it, explaining the mechanisms by which this experience occurred. Throughout the first half of the 20th century, psychodynamic theories were dominant in both psychology and psychiatry. The DSM-II defined depression, according to psychodynamic theory, as a “disorder manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession” (APA, 1968, p.40). As such, early psychoanalysis understood depression as related to loss, guilt and a sense of responsibility for having damaged the lost object (i.e., a significant external figure and the internal representation of that figure; Freud, 1917; Klein, 1975a).

The outcome of this guilt was seen to be viewing the self as worthless, and bad, self-criticism, and wishes to die (Midgley et al., 2013). However, psychodynamic psychiatry then came under fire for lacking scientific rigour, and therefore lacking the medical authority that diagnoses provide (Friedson, 1972). Further to this, psychiatry faced competition from nonmedical professionals who were as qualified as psychiatrists to work with psychosocial difficulties, such as clinical psychologists, psychiatric social workers and counsellors (Abbott, 1988). This gave rise to the diagnostic system seen since the DSM-III was published, as psychiatry's attempt to gain a medical identity (Horwitz, 2011).

Psychodynamic theories saw the occurrence of depression in adolescence as either a developmental crisis or as conflicted anger, and these two theories will be outlined.

#### *Developmental crisis*

Psychodynamic theories formulated depression as a developmental crisis, as adolescents attempt to form their own identity (Freud, 1996). For instance, Laufer and Laufer (1984) focused on the impact of developing a sexual body. This is suggested to reactivate Oedipal conflicts that were previously overcome in toddlerhood (Klein, 1975b/1932), but working through these conflicts during adolescence leads to a young adult sexual and relational identity (Rustin, 2009). This task can sometimes be experienced as overwhelming, and can result in developmental retreat and hopeless withdrawal, or manic and promiscuous activity (Rustin, 2009). Adolescents who had difficulties in early relationships with parents are suggested to experience the developmental changes at this time as more challenging (Bifulco et al., 1987). For example, if these relationships were characterised by excessive closeness, then adolescents may experience difficulties in developing into an individual (Midgley et al., 2013), and struggle with the loss of parental attachments, leading to depression experiences as outlined above.

#### *Conflicted anger*

Busch et al. (2004) propose that adolescents' experiences of depression result from conflicted anger resulting from the loss. Anger is felt to be an



unacceptable emotion, and as such may be denied, and consequently manifest in outbursts of aggression. This could leave the individual and their family feeling distressed. This is suggested to maintain the experience of loss above, as the guilt for experiencing this anger maintains the negative views of the self (Midgley et al., 2013).

Psychodynamic theories, as such, focussed on the mechanisms by which adolescents may have experiences of depression. Lacking in any empirical evidence, these were deemed to be unscientific and unmedical. With the pressures being experienced by psychiatry to meet the standards of other medical professions, these understandings were marginalised in favour of the medical model since the publication of the DSM-III (see *1.6 medical conceptualisations of depression*).

### ***Cognitive-behavioural conceptualisations***

#### *First wave*

Behavioural theories were prominent in the social sciences during the first half of the 20<sup>th</sup> century and became popular within clinical practice since the 1960s (Corcoran & Walsh, 2010). Behavioural theories emphasise the role that an individual's interaction with their environment plays in the onset and maintenance of depression and stem from pioneering work into the principles of learning and conditioning, starting in the early 1900s (Rehm et al., 1981). Ferster (1973) argued that losses in life could also be losses of important sources of reinforcement. The concept of chaining was suggested, where further responses were dependent on that source of reinforcement, such as no longer spending time with like-minded people at work after losing a job. This theory was updated and posits three hypotheses about how an environment provides a lack of positive reinforcement (Lewinsohn & Graf, 1973): the environment does not hold sufficient reinforcement; the individual lacks the necessary skills to access the reinforcement when it is available; even when an individual accesses the reinforcement, they are not able to enjoy it, for instance if they are anxious in a social situation (Abreu & Santos, 2008). It is proposed that, when one of these situations arise, behaviours that are not adaptive for the new environment follow, which further lead to reduced positive reinforcement.

This is suggested to create a self-perpetuating cycle which causes and maintains the experience of depression.

Behaviourism's dominance reflected the increasing emphasis on empirical evidence, as hypotheses could be tested through observation. Early research showed to support this theory, with individuals experiencing depression found to experience a lack of reinforcement compared to individuals who were not experiencing depression (MacPhillamy & Lewinsohn, 1974). Whilst behavioural theories therefore emphasise the role of loss in the experience of depression, similarly to psychodynamic theories, this theory posits that the mechanism by which this occurs is different. Similarly to psychodynamic theory, therefore, behavioural theory assumes that an event precedes the onset of depression for individuals. Behavioural theory is still used dominantly today in psychological therapies for depression, in a method called behavioural activation, whereby individuals gradually increase their access to reinforcement which is proposed to improve depressed mood (Martell et al., 2001).

### *Second wave*

Whilst behavioural theories focus on observable behaviours, there was a shift in focus in the 1960s to the importance of individuals' cognitions, and this was integrated with behavioural theory, giving rise to cognitive-behavioural theory. Beck (1967) posited that dysfunctional beliefs give rise to negative thoughts and are the primary cause of experiences of depression. Beck conceptualises these thoughts in terms of a 'cognitive triad', where an individual has negative thoughts about the self, the world, and the future. However, Beck proposed that experiences in childhood, such a death of a close family member, parental overprotection, or abuse, or bullying and exclusion from peers at school, contribute to the development of the cognitive triad (Beck et al., 1979). Cognitive-behavioural theory suggests that whilst these negative experiences and thought processes predispose an individual to experiencing depression, a stressful life later in life then activates the cognitive triad and leads to the experience of depression. Cognitive-behavioural theories of depression then suggest that an individual's thoughts, feelings, behaviours, and physical

experiences interact to maintain the experience of depression (Greenberger & Padesky, 1995).

However, cognitive-behavioural theory therefore does not explain the experience of depression during adolescence, merely stating that formative experiences at this time can lead to experiences of depression later in life. Nevertheless, cognitive-behavioural therapy (CBT) is one of the most researched and evidence-based psychological interventions for adolescents experiencing depression, having shown longer-term benefits over alternative interventions such as medication (Dardas et al., 2023). CBT is therefore recommended as a first line intervention in CAMHS for adolescents experiencing depression (National Institute for Health and Care Excellence [NICE], 2019). However, the development of CBT within the context of the medical model and its diagnostically driven approach results in standardised protocols which are easy to evaluate (García-Escalera et al., 2016). This standardisation may therefore account for its large, supportive evidence base (David et al., 2018) and could marginalise alternative interventions which are less measurable.

### *Third wave*

At the start of the 21<sup>st</sup> century, the emphasis on CBT began to shift. An individual's relationship with their thoughts and feelings, rather than their content, became the new focus. Models such as Compassion-Focused Therapy (CFT) and Acceptance and Commitment Therapy (ACT) are at the forefront of the third wave CBT movement, conceptualising depression differently. CFT views depression-like states as an evolutionary reaction to an increased sense of threat that cannot be escaped (Gilbert, 2014). ACT, however, takes the view that experiences of depression arise from psychological inflexibility, where behaviour is excessively controlled by thoughts, feelings, or other internal experiences, or to avoid these (Bond et al., 2011). This is suggested to occur at the expense of meaningful or effective actions (Levin et al., 2014).

### ***The Power Threat Meaning Framework***

The Power Threat Meaning Framework (PTMF) was conceptualised as an attempt to move beyond the medicalisation of mental illness and was developed in consultation with individuals with diagnoses of mental illness. The PTMF (Johnstone & Boyle, 2018) represents a shift from asking individuals “what is wrong with you?” to “what has happened to you?”. The PTMF expands on this question, suggesting that they can be posed to individuals or wider systems (Johnstone et al., 2019):

- What has happened to you? (How has power operated in your life?)
- How did it affect you? (What kinds of threats are posed?)
- What sense did you make of it? (What is the meaning of these situations and experiences to you?)
- What did you have to do to survive? (What kind of threat response are you using?)
- What are your strengths? (What access to power resources do you have?)
- What is your story? (Integrating all of the above)

The PTMF therefore proposes that experiences that are conceptualised as mental illness are functional responses to the operation of power in an individual’s life (or a system). The relevance of the PTMF to adolescents has been explored, with its lack of accessibility viewed as a potential barrier to integration of the framework into mental health care practice (Aherne et al., 2019). However, it has been viewed that the principles of the PTMF may be helpful in empowering adolescents to make sense of how their threat responses have served to protect them (Aherne et al., 2019). Further to this, the PTMF positions mental health problems within wider contexts, rather than the individual, reflecting the importance of social context for adolescent development (see 1.2 *adolescence*). Educational psychologists have also found the PTMF helpful to draw upon in their practice with young people (Milligan, 2022). However, they also identified the challenges of changing a system which has contributed to an individual’s experiences of mental health problems (Milligan, 2022).

### ***Evolutionary conceptualisations***

Evolutionary perspectives propose that the experiences of depression stem from defensive strategies of shutting down, an adaptive function for managing unfavourable situations (Gilbert, 2006). These theories suggest that, when faced with an aversive situation in which the fight and flight response is blocked, a depression or withdrawal response become an adaptive coping strategy (Gilbert, 1992). In one study, most individuals experiencing depression reported strong desires to escape difficulties that they were experiencing in their life prior to the onset of their experience of depression, but felt unable to (Gilbert et al., 2004). However, whilst depression or withdrawal may be an adaptive short-term response, a long-term response is viewed as maladaptive, and can occur when the situation is inescapable (not accepted or changed; Nesse, 2000).

The social rank theory (SRT) of depression (Price et al., 1994), attempts to account for the withdrawal characteristics commonly observed. SRT proposes that depression is an adaptive response to losing social status, or being defeated in social competition (e.g., for resources or mates). This is an involuntary response which occurs when the individual is unable to challenge their situation, for example when lacking social power to do so (Sloman, 2000). This could be particularly key for adolescents, as social hierarchies are prioritised and reorganised (Fournier, 2009).

### **1.8 Social, cultural and religious conceptualisations of depression**

Sociocultural perspectives argue that cultural variables can lead to experiences of depression (Gonzalez et al., 2006). These include acculturation (changes to sociocultural structure such as economic and political changes) and enculturation (when older generations impose traditional mindsets on younger generations). Associations between children's psychological adjustment and their perception of being accepted or rejected by their caregivers has been explored. Weaker support from parents has been associated with higher levels of experiences of depression among adolescents (Yap et al., 2014).

The exposure that Western culture has to the psychiatric discourse of depression represents a form of acculturation and is therefore likely to influence experiences of depression in a Western context (Karasz, 2005). However, in cultures where other discourses are more dominant than the psychiatric one, such as religious or spiritual discourses, alternative conceptualisations of depression arise. The Western concept of depression is therefore arguably not universal and can either be understood differently or not experienced at all in different sociocultural contexts (Bowers, 2000). Some cultures, such as those in India, have been reported to view experiences of depression as a normal reaction to severe social or personal threats or losses, rather than a mental illness (Patel et al., 1998). Other cultures, such as those in China, appear to conceptualise their experiences of depression somatically (Kleinman, 1982). Despite somatic presentations, these experiences were able to be compared to the Western concept of depression due to the common contexts in which the experience arises. Chinese and Western individuals both made connections between their difficulties and their experiences of loss, conflict, and emotional pain (Kleinman, 1982). This is further contextualised by the reported social unacceptability of expressing emotions in Chinese culture, and individuals therefore relying on physical discourses when describing their experiences of depression (Kleinman, 1982). Further to this, in some cultures, depression is reported to be a rare experience, such as among the Kaluli of Papua New Guinea, where the culture offers formal opportunities to express or protest loss or frustration, evoking compassion and support from others (Schieffelin, 1985). Increases in experiences conceptualised as depression were found among the Ik in Uganda, following their cultural shift from hunter-gatherer to agricultural workers (Stevens & Price, 2000).

Buddhist perspectives locate depression in a framework of religion that considers all conditions of living as suffering (Obeyesekere, 1985). Depression is viewed by Buddhist perspectives as a state of past or present 'evil mind', associated with greed, jealousy and anger (Schödwell et al., 2019). From this viewpoint, individuals often feel that depression-like experiences are a result of impure actions, either in the past or present. These conceptualisations have implications for individuals' help seeking. For example, individuals in Myanmar,

with influences from Buddhist religion, often seen refuge in religious practices such as prayer and meditation, before they seek help from a Buddhist monk or traditional healer (Schödwell et al., 2018).

Rates of depression diagnosis are reported to be lower amongst individuals who identify as religious or spiritual, compared to those who do not (Lucchetti et al., 2021). Results of a systematic review also suggest that participating in religious practices may play a role in reducing adolescents' experiences of depression (Aggarwal et al., 2023). Spiritual wellbeing (defined as "a sense of life-meaning, belonging and purpose"; Aggarwal et al., 2023, p. 2) was also related to lower levels of depression diagnosis in adolescents (Aggarwal et al., 2023). However, rates of diagnosis may be lower as conceptualisations of depression in these populations may not reflect the psychiatric understanding. Nevertheless, literature suggests that religiosity and spirituality have implications for conceptualisations of depression.

Even within cultures, individuals have been reported to conceptualise depression differently. Gender has been repeatedly associated with differences in rates of diagnosis, with research reporting that females are twice as likely to receive a diagnosis of depression than males (Salk et al., 2017). This gender difference first appears during adolescence, prior to which rates of diagnosis are equal between girls and boys (Salk et al., 2017). However, the higher rates of diagnoses of depression in adolescent females, compared to males, have not been identified in non-Western cultures (Piccinelli & Wilkinson, 2000), suggesting the role of cultural factors. The higher rates of diagnosis of depression in females across the lifespan may reflect their experiences of depression aligning with diagnostic criteria (Halbreich & Kahn, 2007; Silverstein et al., 2013). In this sense, it is reported that men often do not reach out for support from MHS because they do not relate to the language used by services and diagnostic systems (Men's Health Forum, 2018). The language preferred by men in the UK to describe mental health was highlighted in the document 'Mind Your Language' (Men's Health Forum, 2018). For example, men have been found to prefer terminology such as "stressed", "tired" and "not going too well" to describe their experiences of depression (Shand et al., 2015). This contrasts

with male mental health professionals identifying “depressed” as an acceptable term to use (Men’s Health Forum, 2018), demonstrating the discrepancy between MHS’ and males’ conceptualisations of depression. Further to this, young males between the ages of 13 and 16 preferred the term “depressed” to “sad” (Men’s Health Forum, 2018). This suggests that there are differences in the conceptualisations of depression within a gender within Western cultures, and that these differ to professionals’ and MHS’ conceptualisations. This further suggests that there is no one truth of what constitutes depression, and that it is a socially constructed concept.

### **1.9 Adolescents’ conceptualisations of depression**

Some research has explored how adolescents experience, describe, or conceptualise depression, although adolescents’ narratives have been marginalised within this. Hickie et al. (2007) explored young people’s perspectives of depression. However, participants were described as “quite knowledgeable” about depression. This suggests both that participants’ language is assumed to be representative of underlying cognitive processes, and that their understandings are being framed within the context of a correct ‘truth’. These participants also lived within a sociocultural context that is considerably different to adolescents’ current one, for example prior to the covid-19 pandemic so may not reflect the experiences of current adolescents. Further to this, Bear et al. (2021) explored young people’s experiences of depression based on a pre-existing model, the cognitive model of illness representation. This model of illness representation assumes that language represents underlying cognitions which then influence behaviours and reinforce cognitions, therefore taking a structuralist perspective. Further to this, whilst researchers stated that they inductively analysed new data, findings appeared to be reflective of the model of illness representation that the research was based upon. This suggests that participants’ narratives were limited to those assumed by a cognitive model. Further to this, the participants in both the Hickie et al. (2007) and the Bear et al. (2021) studies were aged between 18-25 years old and therefore, despite varying definitions of adolescence, arguably have different sociocultural experiences to adolescents younger than this. For



example, younger adolescents' social worlds still exist within the context of school, which may bring different experiences.

Martin and Atkinson (2018) conducted a systematic review of the narratives used by young people to communicate depression. Participants from the studies that were included in the review identified that life experiences, including adversities, were triggers of their experiences of depression, as were the pressures of social expectations and peer comparisons. Some participants also described struggling with talking about their experiences of depression, feeling that they were not worthy of others' attention. Participants also used social media to communicate their experiences of depression, but face-to-face communication was perceived as preferable, although sometimes more difficult to engage in. Participants felt that communication with others was a way of feeling connected but also accessing support, although preferred to talk to others who were not their parents. Participants from the included studies were aged between 14 and 34, so results should be interpreted within this context, although the systematic review aimed to understand the narratives used by those who were between 16 and 25 years old.

De Mol et al. (2019) used interpretative phenomenological analysis (IPA) to explore the agency of adolescents experiencing depression. Participants explained that they became more sensitive to others' opinions of them, and that experiencing depression meant that they had failed to cope, which was socially unacceptable. Participants felt that this induced their experiences of depression, and they felt that they were losing their agency to change these experiences and feel better. Further to this, participants felt the need to hide their experiences of depression from others due to being anxious about others' judgements and social exclusion, leading to a sense of social isolation. They felt that their experiences were minimised or trivialised by others, sometimes because they were unable to provide explanations for their feelings of depression. Pressures within social relationships were also identified by participants to play a key role in their experiences of depression. For example, they felt that they should know how to act in social situations to be seen as normal, and not being in a romantic relationship was not normal. Participants

highlighted the role of working towards something in the future to maintain their personal and social wellbeing, but that this was also a social expectation. This study therefore highlights the social discourses drawn upon by adolescents to describe their experiences of depression. The use of IPA enabled in-depth exploration of individuals' experiences of depression and sense they make of these. However, IPA assumes that language is representative of internal experiences, such as cognition, rather than constructive of meaning. Due to this, IPA is unable to explore how language is used by adolescents, nor situate narratives used within wider discourses, and understand the implications for power. Further to this, De Mol et al. (2019) recruited participants experiencing depression from a psychiatric hospital. These participants may therefore have different experiences of depression to the adolescents in the community, and hospitalisation may have influenced their lived experiences.

### **1.10 Conceptualisations of recovery**

The concept of recovery is considered to reflect that of mental health problems, representing a "multidimensional set of phenomena" (Davidson & Roe, 2007, p.460). As such, reflective of conceptualisations of depression, and in line with a social constructionist perspective, there is no single truth of the concept of recovery (Jacob, 2015).

Psychiatry's early success with antidepressant medication led to a sense of optimism about recovery; that individuals will recover from their mental illness and live life with their premorbid levels of functioning (Jacob, 2015). As such, the medical model of mental illness views recovery in a similar way to physical illnesses, and the course of depression has been conceptualised in terms of remission, recovery, relapse, and recurrence (Frank et al., 1991). These conceptualisations therefore endorse the medical model, focussing on the diagnostic criteria for depression no longer being met. However, unlike for most physical illness where end points of treatment are well-defined, both patients and clinicians find it difficult to recognise when recovery from depression has been achieved. Whilst antidepressant medication can reduce the severity of experiences of depression, many individuals experience ongoing symptoms even after long-term prescription of antidepressant medication (e.g., Solomon et

al., 1997). Considering this, whilst some individuals experienced complete relief from symptoms, others were able to live meaningful lives despite the presence of these symptoms (Davidson & Roe, 2007). Alternative conceptualisations of recovery therefore began to arise to account for these differences in experiences.

The recovery model arose during the 1980s, pioneered by those experiencing mental health problems, and began to reflect the idea of recovery as a process rather than an event (Jacobson & Greenley, 2001). This debate is ongoing, and recovery may represent different meanings for different people (Simonds et al., 2014). Nevertheless, this reflected an ultimate shift from medical meanings of recovery, as it began to instead be conceptualised as “a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993, p.13). The increasing research into recovery gave rise to a new conceptual framework of recovery. A systematic review of 97 papers identified five key processes of recovery: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (CHIME; Leamy et al., 2011). However, this systematic review did not identify any studies relating to adolescents and it is argued that models based on adult conceptualisations are not appropriate for use with younger people (Simonds et al., 2014). For instance, ‘connection’ is likely to be a more complex process for adolescents given the social reorganisation that takes place at this time. The formation of their identities is also likely to influence adolescents’ experiences and perspectives of recovery (Ward, 2014).

Adolescents have recently conceptualised recovery as: evolving identity; establishing connection; and exercising autonomy (Arbour et al., 2023). However, this only reflected seven adolescents’ experiences, all of whom were recruited from a mental health hospital, an environment which likely influenced their conceptualisations of recovery. A scoping systematic review identified 8 papers exploring adolescents’ conceptualisations of recovery, which appeared to reflect the CHIME framework (Naughton et al., 2018). However, parental, and

wider systemic roles in recovery journeys were also highlighted, and there was contention about the use of recovery language being confused with traditional psychiatric concepts of 'cure' (Naughton et al., 2018). A study exploring adolescents' conceptualisations of recovery from anxiety and depression identified three themes: loss of self; renegotiating the self; anticipation of future self (Simonds et al., 2014). Whilst adolescents felt a sense of uncertainty about themselves as they withdrew from people and activities they used to connect with, a process of renegotiation then appeared to occur. Instead of identifying and reconnecting with their lost prior self, they negotiated a new self-concept. However, adolescents appeared to describe a significant amount of ambivalence towards this process, such as talking to others about how they are feeling. Adolescents also shifted their focus to the future, as they anticipated achieving their aspirations, and identified a sense of maturation providing a means for change. Whilst these papers begin to provide a sense of adolescents' conceptualisations of recovery, none focus specifically on recovery from experiences of depression. Experiences of depression are likely to construct different experiences of recovery, compared to experiences of anxiety. For instance, it could be hypothesised that adolescents' ambivalence about recovery in the Simonds et al. (2014) study is specific to experiences of anxiety, with worries about the future.

### **1.11 Guidelines and services for adolescents experiencing depression**

The NICE (2019) guidelines for children and young people experiencing depression detail what care should look like from MHS. These guidelines highlight the importance of considering the context that the individual presenting to services is living within. For example, the guidelines state that the "social, educational and family context for the patient and family members, including the quality of interpersonal relationships, both between the patient and other family members and with their friends and peers" (NICE, 2019, p. 49) should be explored. Further to this, the importance of understanding this context is emphasised due to the negative impact any wider contextual factors may have on the individual's recovery (NICE, 2019). Healthcare professionals are recommended to assess, in collaboration with the young person, their social network, and a written formulation should also be developed prior to the start of

any treatment (NICE, 2019). This formulation should identify factors that have contributed to the development and maintenance of the young persons' experience of depression and may additionally impact on efficacy of treatments offered. When bullying is a factor, collaborative efforts should be made by healthcare and educational professionals to prevent bullying (NICE, 2019).

Further to this, the guidelines state that mental health problems being experienced by parents of the young person accessing CAMHS should be explored, and the parallel treatment of this should be considered. Young people experiencing depression should also be provided with information about physical activity, sleep hygiene, and a balanced diet (NICE, 2019). Overall, therefore, the NICE guidance uses a psychological and systemic narrative to mental health care for young people experiencing depression, therefore locating an adolescents' experience of depression within social contexts, rather than within an individual, as a mental illness. Further to this, the NICE (2019) guidelines do not recommend the prescription of antidepressant medication as the first line of treatment for young people experiencing depression, instead endorsing psychological therapies including CBT, interpersonal therapy for adolescents, and family therapy. This guidance highlights that only one type of antidepressant is licenced for use with adolescents experiencing depression, due to the risks of others outweighing their benefits (NICE, 2019). NICE (2019) guidelines for mental health care of adolescents experiencing depression therefore do not endorse a medical discourse and therefore medical approach to care.

The Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) shifted the way that mental healthcare was commissioned, with a move to outcomes-based payments. This reflects a shift that had already taken place in physical healthcare settings and aimed to establish a parity of esteem between mental and physical healthcare (Monitor and National Health Service [NHS] England, 2015). Outcomes used for CAMHS include patient-reported outcome measures, clinician-reported outcome measures, or patient-reported experience measures (Edbrooke-Childs et al., 2016). Standardised measures are often used for outcomes, and are recommended by guidelines, such as the Strengths and Difficulties Questionnaire (NICE, 2019). It has been argued that these may

be useful for comparing change in groups of patients but may not represent individuals' experiences (Norman et al., 2014). Further to this, the standardised measures that are used often focus on symptom reduction, therefore dismissing other relevant outcomes such as coping skills (Batty et al., 2013). These outcome measures therefore tend to reflect the medical view of recovery, conceptualising it as a goal instead of a process. However, CAMHS are commissioned based on these measures, therefore arguably reinforcing the medical model, unlike the NICE (2019) guidelines.

Children and young people can struggle to access mental health services due to not meeting the eligibility criteria (Care Quality Commission [CQC], 2018), and these criteria are suggested to be inappropriately high, creating an unnecessary barrier to support (CQC, 2018). Children and young people, and their families, have reported feeling frustrated and disappointed when their wishes for their care were not listened to, or they were not given choices for their care (CQC, 2018). Adolescent females experiencing depression have described their difficulties with communication and feeling understood, which impacted on their help-seeking behaviours (Shaw et al., 2009). Considering adolescents' lack of power to make change to their mental health care (Stige et al., 2021), and their difficulties communicating how they are feeling, it is likely that when adolescents' views are not emphasised by services, they are not incorporated into their care. Children and young people have reported positive experiences of services that took a flexible and personalised approach and empowered them to design their own care, with improvements for their recovery also reported (CQC, 2018). Dominant discourses, such as medical or psychological ones for depression, can marginalise individuals who do not adopt them (Dunn & Neumann, 2016). It is therefore arguable that outcomes and experiences improve when adolescent perspectives are included within their mental healthcare because professionals allow space for adolescents' less accepted discourses.

Existing guidelines recommend psychological therapies as an effective intervention for adolescents experiencing depression (NICE, 2019). However, research has reported that up to 37% of adolescents experiencing depression

stopped engaging in psychological therapy without the agreement of their therapist, and 11% did not take up the treatment that was offered (O’Keeffe et al., 2019). This is considerably more than the proportion of adults who have been reported to stop engaging in CBT for depression (24.63%; Hans & Hiler, 2013). Adolescents have reported that they refuse the care offered to them when they have felt misunderstood or dismissed by mental health services (Macdonald et al., 2021). Only 15% of adolescents have reported to stop taking their prescribed antidepressants (Rohden et al., 2017), suggesting that this approach may be more in line with their conceptualisations of depression and recovery. However, this could also be a result of the experience of depression itself. For example, individuals experiencing depression may find it more difficult to attend therapy appointments regularly, due to how they are feeling, than take antidepressant medication. One study found that adolescents who stopped engaging with CBT, for example, were six times more likely to meet diagnostic criteria for depression, than those who continued to engage (O’Keeffe et al., 2019). This could suggest that experiencing depression itself can impact the effectiveness of interventions. However, research may also indicate that adolescents’ experiences do not align with either the medical or psychological discourse, and that they lack power to change their mental health care, unless directly empowered by services.

### **1.12 Extended rationale**

The consequences of adolescent depression largely remain overlooked (WHO, 2021) and without the right support, the mental health of young people can deteriorate (CQC, 2018). Adolescents report feeling dismissed by services, unable to access the support that they would like, or feel that they need (CQC, 2018). The poor conceptualisation of the experience of adolescent depression has been identified as a gap in the literature (Rikard-Bell et al., 2022). The sociocultural changes in recent years have impacted on the experience of adolescence itself. Considering that the concept of depression is socially constructed, it is therefore likely that adolescents’ experiences and conceptualisations of depression have shifted with the sociocultural changes.

Psychological formulations and interventions arguably allow more space for adolescents' conceptualisations to be acknowledged, compared to medical conceptualisations. However, to access these interventions, access to a mental health service with specific eligibility criteria is still required. Further to this, adolescents experiencing depression frequently disengage when offered support. This suggests that their conceptualisations of recovery differ to those held by mental health services, as supported by research that has been explored. Further to this, whilst a psychological approach may offer an alternative understanding for adolescents, it is still framed within the medical model, and may not align with adolescents' conceptualisations of depression or recovery. Adolescents' conceptualisations of depression and recovery may lie outside of discourses frequently drawn upon by literature and mental health services and are therefore dismissed. Given adolescents' structural position in society, they lack power to challenge dominant discourses. Adolescents' conceptualisations of depression and recovery must therefore be understood by those surrounding them, including caregivers, schools, and mental health services. Understanding how adolescents conceptualise depression and recovery would create a starting point to the development of appropriate pathways of care, and alternative models for assessment, formulation, and intervention.

## **2. Extended Method**

### **2.1. Epistemological Considerations**

Psychological research historically inherited its epistemological orientation from scientific research methods, namely taking a positivistic stance (Cacioppo et al., 2004). Positivism claims that there is one 'truth' to be discovered, and that this is possible through measurement of phenomena in controlled experiments (Ponterotto, 2005). For example, randomised controlled trials are considered the 'gold standard' for researching effectiveness of psychological therapies.

Social constructionism (SC) challenges positivism, instead arguing that it is not possible to observe a single truth and that no one way of understanding is any nearer to the truth than others (Gergen, 1985; Burr, 2015). Instead, SC takes the position that multiple realities exist at one time (Gergen, 2015). A



critical stance is therefore taken towards ways of understanding the world which are taken for granted and SC asserts that these understandings are culturally and historically specific (Burr, 2015). Further to this, SC takes the perspective that knowledge is constructed and maintained through social processes such as language and is also historically and culturally constructed in this sense (Gergen, 1985). Each social construction is suggested to bring social action with it accordingly, consequently sustaining the constructions themselves (Burr, 2015). Language is therefore an important object of analysis for research from a social constructionist perspective (Burr, 2015). Burr (2015) identifies two levels of SC: whilst micro-SC sees social construction occurring within everyday interactional talk between people, macro-SC acknowledges that the constructive power of language is bound up within social structures and institutionalised practices (Burr, 2015). Power, as a concept, is therefore at the heart of macro social constructionism, which is therefore particularly concerned with analysing forms of social inequality, including mental health (Burr, 2015). An SC perspective, at both macro and micro levels, is therefore congruent with this study's aim to understand how adolescents conceptualise depression and recovery.

It is also important to consider that the researcher is not able to step outside of their own 'knowledges' of reality and therefore they must acknowledge the co-production that occurs between themselves and participants during data collection (Burr, 2015). It is therefore especially important for the researcher to engage in reflexive practices throughout the research.

## **2.2. Methodological Considerations**

In contemplating the best way to answer the research questions, different qualitative methodologies were considered, including thematic analysis (TA), interpretative phenomenological analysis (IPA), grounded theory (GT) and discourse analysis (DA).

### **2.2.i. Thematic Analysis**

TA is a method of identifying and analysing patterns of meaning (themes) in data (Braun & Clarke, 2006; 2012). TA is not bound by theoretical or

epistemological assumptions, and therefore can be a flexible approach used for almost any qualitative research (Braun et al., 2022; Braun & Clarke, 2012). TA can take a more descriptive focus, at the semantic level (Braun & Clarke, 2006), or a more interpretative focus, at the latent level (Braun et al., 2022). However, TA is criticised for being comprised of aspects that are common to many qualitative methods (Ryan & Bernard, 2003) and is at risk of being used inappropriately as a result. TA also does not closely question how language constructs and maintains understandings of the world, nor how this is bound up in wider social structures and was therefore not deemed an appropriate methodology for this research.

### ***2.2.ii. Interpretative Phenomenological Analysis***

IPA focusses on in-depth exploration of individuals' personal experiences of phenomena (Smith et al., 2021), the meanings they attach to these experiences, and the sense they make of them (Smith, 2011). IPA is therefore a cognitivist methodology, assuming a relationship between language and underlying attitudes or thought. Due to its idiographic lens, IPA does not aim to generalise results, instead making general claims that are more tentative. IPA also emphasises hermeneutics, acknowledging that biases and assumptions are inevitable in research, as the researcher is interpreting the participants' interpretation (Smith & Eatough, 2007). IPA can ask critical questions of the data, specifically whether the participants' mental and emotional state are unintentionally indicated within their speech (Smith & Osborn, 2015). IPA is therefore concerned with individual cognitive sense-making processes of an experience, rather than social processes. For example, IPA might ask questions such as "what is it like to experience depression and recovery as an adolescent?". IPA's assumption that language is a route to discovering underlying beliefs was not consistent with the aims of the current study, which takes a social constructionist perspective with a focus on the role of social processes in creating reality.

### ***2.2.iii. Grounded Theory***

GT has been described as "a way to learn about the worlds we study and a method for developing theories to understand them" (Charmaz, 2014; p17). As

such, GT studies the external world and generates a theory from this data, aiming to expand, develop or challenge existing theoretical understandings of a phenomenon (Charmaz, 2015). Originally a positivist methodology, GT has developed over time and can take a constructionist approach which focuses on participants' construction of meaning in relation to the phenomenon in question (Charmaz, 2015). Therefore, GT differs to IPA in its aim to both understand and explain a phenomenon, rather than provide an understanding of individuals' interpretations. A GT approach may therefore have the aim "to generate a theory, grounded in adolescents' unique experiences of depression and recovery, which explains the meanings constructed in relation to these experiences". Due to the current project's aims to examine the use of language in adolescents' constructions of depression and recovery, GT was not deemed an appropriate methodology.

#### **2.2.iv. Discourse Analysis**

DA is a methodology which aligns with a social constructionist epistemological stance, with the assumption that social processes such as language actively construct different versions of reality. Whilst there are many different approaches to DA, two main approaches are used in the present research: discursive psychology (DP; Potter & Wetherell, 1987) and Foucauldian discourse analysis (FDA; Willig, 2008). These different approaches map onto micro and macro social constructionism perspectives respectively (Burr, 2015).

##### *Discursive Psychology*

DP emphasises three main principles based on observations about the nature of discourse (Potter & Wetherell, 1987):

- Firstly, DP argues that discourse is both constructive and constructed (Wiggins & Potter, 2008). Language is constructive in that it brings versions of the world into being that would not putatively exist without the talk. Language is constructed in that it is made up of linguistic devices which are used in a variety of ways to create these versions of the world. DP is interested in how language is constructed and how it is used to construct (Willig, 2008).

- Secondly, DP assumes that discourse is oriented to action. Talk itself can achieve action such as blaming or justifying using discursive devices; the dichotomy of talk and action often assumed within psychology is therefore seen as false (Wiggins & Potter, 2008).
- Thirdly, DP states that discourse is situated within its specific sequential environment. Words should be understood according to what precedes and follows them, and they are situated within a particular setting, for example within a research interview, answers would be expected to follow questions. Research participants may, however, withhold their answers to the question, partially or completely, and this would be of interest from a DP approach. Discourse should therefore be examined within its situational context (Wiggins & Potter, 2008).

DP therefore aligns directly with micro social constructionism, concerned with the rhetorical devices used by people to achieve interpersonal objectives within local interactional contexts (Willig, 2008). A DP approach therefore does not typically consider wider socio-cultural discourses.

#### *Foucauldian Discourse Analysis*

FDA is a term used to refer to methods of analysing talk which are influenced by post-structuralist perspectives and, notably, the work of Michel Foucault (Willig, 2008). FDA argues that language is constructive, rather than descriptive, of reality, in line with social constructionist perspectives. Language therefore is suggested to construct dominant discourses, which are then maintained by becoming assumed as the 'truth' (Alvesson & Kärreman, 2000). Discourses therefore both enable and constrain who can say what, where and when (Parker, 1992), with availability of discursive resources dependent on sociocultural factors. Discursive resources that are available within a certain sociocultural context have implications on those who live within it, making available certain ways of seeing and being within the world (Willig, 2008). Foucault did not provide any direct analytic guidance for conducting FDA, but methods have been described by others. Willig (2008) defines six stages of

conducting FDA, which are not restrictive but provide guidance to facilitate the analysis:

1. Discursive constructions. The first stage of analysis aims to identify how discursive objects are constructed in the talk. Within this research, for example, the discursive objects were depression and recovery. This stage therefore involves identifying sections of text in which these objects are talked about, both implicitly and explicitly.
2. Discourses. The second stage aims to locate the discursive constructions of the object within wider discourses and therefore the differences between how the objects are constructed throughout the text.
3. Action orientation. The third stage aims to analyse the context of the different discursive constructions more closely. In doing so, the function of constructing depression or recovery in such a way at that certain point in the text is examined.
4. Positionings. The fourth stage aims to identify the subject position that the discourses offer. Subject positions identify “a location for persons within the structure of rights and duties for those who use that repertoire” (Davies & Harré, 1999, p.35). As such, discourses are suggested to make available positions for speakers to take up and place other people within.
5. Practice. The fifth stage is concerned with examining how discourse and practice are related. It therefore identifies the ways in which the discursive constructions within the talk create or remove opportunities for action.
6. Subjectivity. The final stage in FDA aims to trace the consequences of the discursive positionings on the individuals’ subjective experience. In other terms, this stage is concerned with exploring what it is like for the individual to see and be in the world from the position their discursive constructions place them in.

Further to these steps, FDA assumes that power and discourse are fundamentally interlinked, as discourse is influenced by power but also maintains and reinforces it. In this sense, dominant discourses becoming assumed as ‘common sense’ and ‘truth’ validates versions of social reality

which legitimate existing power relations and social structures, but marginalises other versions of reality (Willig, 2008; Milliken, 1999). Further to this, Foucault argues that discourses are constrained by institutional practices and power (Foucault, 1981). This is particularly key for this research study, as it is impossible to ignore the power at play in adolescents' lives and in their experiences of depression and recovery. Whilst discourses construct reality and reproduce common sense, FDA aims to determine how this takes place, and question the phenomenon that appear to be most obvious, to identify the difficulties they pose (Foucault, 1969/2002).

Willig (2013) specifies that if the research question is to understand how a group of people construct meaning in relation to a topic, it makes sense to work with transcripts of semi-structured interviews. However, it is suggested that if this data is being analysed in relation to expert discourses, a variety of 'expert' texts also need to be analysed (Willig, 2013). FDA has been used to compare discourses of the same construct (e.g., Ahl & Nelson, 2015), allowing for the identification of the discursive practices that are present, or absent in both.

#### *Combining DP and FDA*

DA, using a combination of both DP and FDA, was therefore the most appropriate methodology to explore the research questions. Burr (2015) emphasises that macro and micro social constructionism are not mutually exclusive and can be used together in a synthesis. It is in fact argued that research should take account of both local contexts and wider social structures of talk, within which they are constructed (Wetherell, 1998). A combination of both DP and FDA has therefore been proposed as best practice for DA (Alvesson & Kärreman, 2000). Taking a mixed FDA and DP approach to analysis enables a balance between features of the texts and broader discursive aspects. When analysis focusses more heavily on macro level processes, it may rely on these to explain an account when the micro level processes may provide more immediate reasons (Speer, 2005). Therefore, this combined approach was taken in the hope that both levels of explanation could be explored. There is no one method to conduct DA, as it depends on both the theoretical orientation of the researcher and the research questions. DA does

not aim to uncover internal processes, as it is not a cognitivist method, and instead views language as playing a role in both the construction and maintenance of constructions of concept. Previous research has successfully combined DP and FDA with individuals experiencing mental health problems (Malson & Ussher, 1996).

### **2.3. Ethical Considerations**

Ethical approval was granted by the University of Nottingham's (UoN) School of Medicine research ethics subcommittee on 19<sup>th</sup> April 2023 (Appendix A). An amendment was submitted on 25<sup>th</sup> May 2023 and subsequently approved on 5<sup>th</sup> July 2023 (Appendix B). The amendment enabled interviews with participants to also take place over text format (i.e., email or chat function). This was in response to requests from potential participants, and aimed to make reasonable adjustments for individuals who would like to take part in an interview but found it difficult to speak about their experiences of depression. For all ethical considerations, the National Children's Bureau (NCB) guidelines for research with children and young people (Shaw et al., 2011), and the British Psychological Society (BPS) guidelines for ethical practice in psychological research online (BPS, 2021) were both referred to.

#### **2.3.i. Confidentiality**

To ensure participant confidentiality, identifiable information that was collected (such as consent form and contact details) was held securely and only accessible to the primary researcher, separately from the data. Participants were each given a unique pseudonym to ensure that they could be identified should they wish to withdraw from the study, and the appropriate data subsequently removed. Identifiable data was removed from interviews throughout the transcription process.

All participants provided contact details of a trusted adult and their location for the duration of the interview, for use if an emergency occurred throughout the interview, however this did not happen in any interviews. Participants were

aware that their confidentiality would be breached in the case of an emergency and all participants provided informed consent for this.

### **2.3.ii. Informed Consent and Right to Withdraw**

Each participant saw the recruitment advert (Appendix C), or textual advert if recruited via charity (Appendix D), and a participant information sheet appropriate to their age (Appendices E and F) prior to consenting to participate in the study (see Appendix G for consent form for participants aged 16+; see *2.5 recruitment procedure* for recruitment and consent process for participants under 16). All participants were recommended to discuss their decision to participate or not with a trusted adult, in line with NCB and BPS guidelines (Shaw et al., 2011; BPS, 2021). The email addresses of the primary researcher and supervisors were provided; participants and parents/carers were encouraged to email with any questions both prior to and following participation. All participants were deemed to have the capacity to give informed consent.

Participants were asked to confirm their consent verbally immediately prior to their interview. Participants were also informed, and reminded throughout the interview, that they could take a break or end the interview at any time without needing to provide a reason. One participant left the chat mid-interview, but soon emailed explaining that their laptop had run out of battery and requested to finish the interview the following day, which was successful. Participants were aware prior to consent, and reminded at the start and end of the interview that they had the right to withdraw their data from the study up to one week following their interview, without the need to give a reason. No participants withdrew from the study.

### **2.3.iii. Risk of Harm**

It was not expected that participation in this study would cause any physical or psychological harm. The researcher acknowledged that discussing personal experiences of depression and recovery may be distressing for participants. In consideration of this, participants were informed, and reminded throughout the interview, that they may choose to skip any question and only share what they



wished to, and that they could stop the interview at any point. The researcher remained observant throughout the interviews of any potential signs of distress. Where observation was not possible (i.e., over voice call or chat interviews), the researcher regularly asked the participant whether they wanted to continue the interview or not. No participants became significantly distressed during the interviews, however some were evidently hesitant in discussing past experiences. In these instances, participants' wellbeing was prioritised, with the researcher asking if they were okay and suggesting a break in the interview.

When the interview concluded, some debrief time was spent with the participant, discussing how they were feeling following the interview, and whether there was anything that they would like to discuss that the interview had brought up for them. If thoughts of self-harm or suicide were mentioned within the interview, these were discussed in relation to how they were in the current moment. Participants were asked what they were planning to do following the interview, to ensure that they had a period of reflection or meaningful activity to engage in as a segue back to the remainder of their days if they felt they needed this. Participants were sent a debrief sheet following the interview to remind them of their rights to withdraw and contact details of support services (Appendix H).

#### ***2.3.iv. Reimbursement of Participants***

NCB guidelines recommend that participants receive appropriate rewards and recognition for their involvement, with a high-street gift voucher being appropriate for one-off participation (Shaw et al., 2011). It is important to consider power imbalances between child participants and adult researchers, due to adult centredness of most societies being duplicated in research processes (Punch, 2002). The Health Research Authority (2014) suggests that participant incentives reduce potential power imbalances between participant and researcher, by making their participation seem less like a "favour".

To show participants that their time was valued, they each received a virtual £10 Amazon gift card upon completion of the interview, to their preferred email address. Gift cards were sent directly to participants, rather than via

parents/carers, as to empower adolescents, considering the potential power imbalance in relationships with caregivers.

### **2.3.v. Website Terms of Use**

Following identification of appropriate website data, privacy and copyright policies of each website were referred to. Website data was only included in the study where policies allowed, or where fair dealing rules provided an exception to copyright law (Intellectual Property Office, 2014). Where this was the case, websites were contacted to inform them of the intention to use their data in a research project under the fair dealing rules.

### **2.3.vi. Data Management**

All researchers endeavoured to protect the rights of the study's participants to privacy and informed consent and adhered to the General Data Protection Regulations in the Data Protection Act (2018). The interview transcripts were anonymised, and participants were assigned pseudonyms. The electronic audio recordings of the interviews were held on OneDrive and were password protected. Once transcribed, audio recordings were deleted. All electronic data was held securely, and password protected. Access was restricted by user identifiers and passwords (encrypted using a one-way encryption method). Access to information was limited to the study staff and investigators and any relevant regulatory authorities.

In compliance with Good Clinical Practice guidelines and the University of Nottingham code of research conduct and research ethics, the lead researcher will maintain all records and documents regarding the conduct of the study. These will be retained for at least seven years. If the lead researcher is no longer able to maintain the study records, a second person will be nominated to take over this responsibility.

## **2.4. Participants and websites**

### **2.4.i. Sample Size**

Sample size in qualitative research is dependent on epistemological, methodological, and practical issues (Baker & Edwards, 2012), and there is no

prescriptive sample size recommendation for DA specifically. The appropriate amount of data depends on the specific research question, but DA often relies on small numbers of texts as too much data becomes prohibitive of the analysis (Georgaca & Avdi, 2011). A minimum of 8 interviews with participants is recommended for DA (Georgaca & Avdi, 2011) and this is also in line with previous research with young people that have used DA (e.g., Prior, 2012). In line with recommendations (Georgaca & Avdi, 2011), this research aims to collect between 8 and 20 texts to ensure a balance between sufficient data, without the amount of data becoming too large for detailed analysis. The recruitment period ended when there was no further interest generated by the recruitment advert; by this point, 12 participants had been recruited and 8 websites had been identified, reaching the maximum texts in total for analysis.

#### **2.4.ii. Eligibility Criteria**

See Table 2 for exclusion criteria and Table 3 for inclusion criteria for both participants and websites. Due to the nature of online recruitment, some characteristics could not be confirmed, but were assumed, for example that participants were honest about their age and parental contact details where required, and that all information had been read prior to giving consent.

**Table 2**

*Exclusion criteria for participants and websites and their justifications*

Participants will be excluded if:	Justification
They have a diagnosis of an Intellectual Disability	It is possible that the different needs for this group of people would require a different approach to data collection
<hr/>	
Websites will be excluded if:	
They are chat rooms or discussion groups.	This aspect of the research is targeting expert discourses, so any service user perspectives are not relevant and may additionally pose issues with keeping data confidential.

**Table 3***Inclusion criteria for participants and websites and their justifications*

Participants must be:	Justification
Aged 12-17	This study is focussing on adolescents' understanding of depression. Adolescent mental health care stops after the age of 17. Under 12s may need adaptations due to the different context that they are in at primary school.
Currently experiencing depression/low mood	This study is aiming to understand the current discourses that adolescents are using. Discourses can change over time and context.
Able to provide informed consent if aged 16-17	Participants need to understand the benefits and disadvantages of participation, to be able to make an informed decision about whether to take part.
Able to provide informed consent from someone with parental responsibility for them if they are under the age of 16.	Guidelines for research with children state that those under 16 require parental informed consent to be able to take part. These participants will also be asked to provide their assent.
Be able to read and communicate verbally in English	Participants need to be able to read and understand the information sheet and consent form and participate in the interview.
<hr/>	
Websites must:	
Be written in English.	Translation of websites will alter meanings and therefore discourses that are being analysed.
Be aimed at, or suggested by, adolescents or parents (or both)	This research is aiming to understand the dominant discourses of adolescent depression, within the context of the power that is at play in adolescents' lives. If the websites are aimed at parents, these discourses may also be playing a role in adolescents' lives.

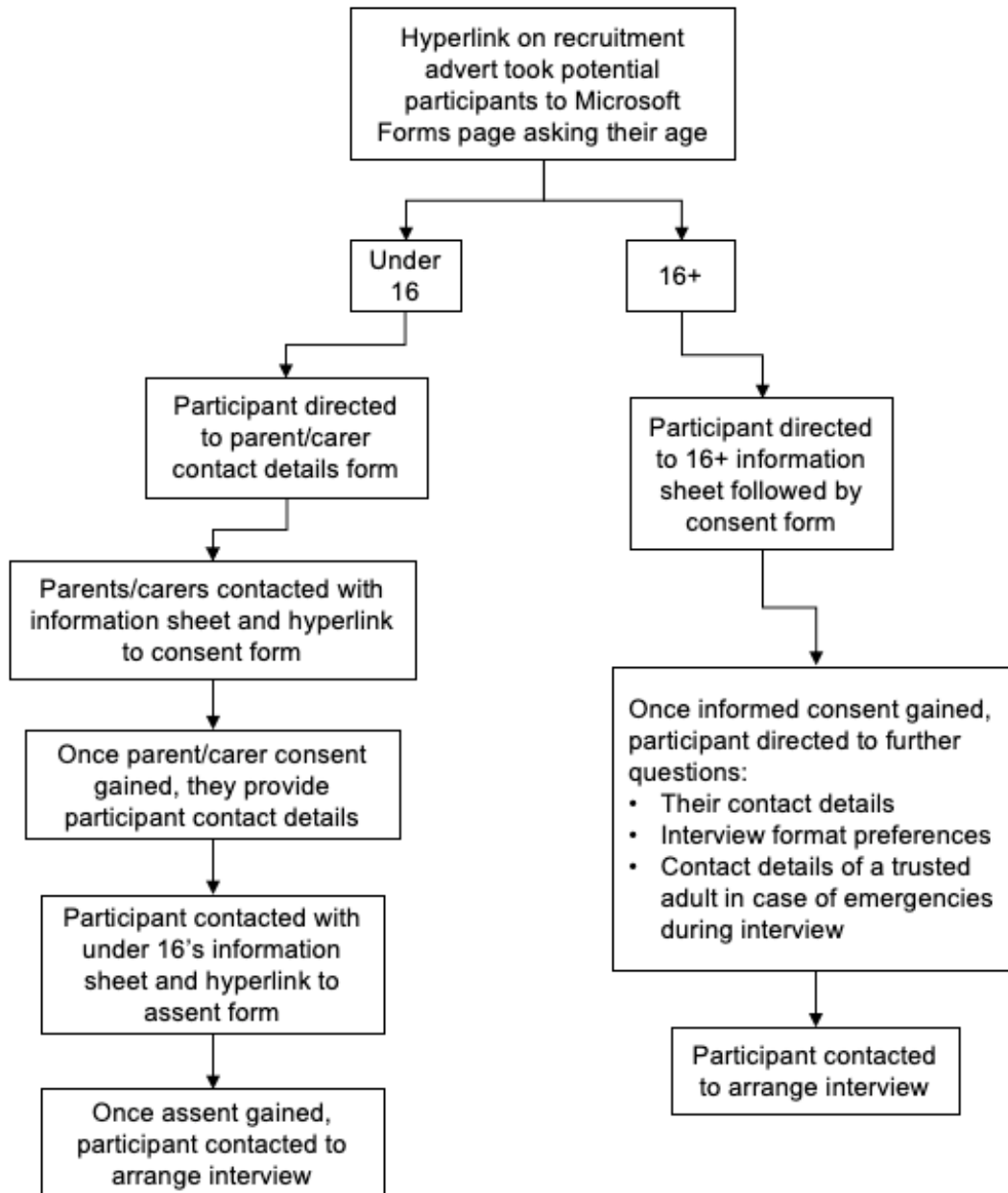
## **2.5. Recruitment Procedure**

Participants were recruited using advertisements posted on social media and websites of mental health charities for children and young people (Appendices C and D). In line with guidelines for research with children and young people (Shaw et al., 2011), the recruitment procedure varied according to participant age (see Figure 2). Participants who wished to contact the researcher for more information were able to do so directly.

For participants under 16, consent was required from an adult with parental responsibility in advance to the participants' assent (see Appendices I, J, K, L and M for: parent/carer information sheet; contact details form; example initial email to parents/carers; parent/carer consent form; and assent form for under 16s).

**Figure 2**

*Age-dependent recruitment procedure*



## **2.6. Identification of Websites**

Young people most commonly use text-based internet searches using a search engine to seek information and help in relation to mental health (Pretorius et al., 2019). With Google as the most used search engine worldwide (Johnson, 2022), this was used to search for relevant websites. Results on the first page of search engine results receive nearly 95% of the web traffic (Fay, 2022) and the entire webpages of the first page of results were therefore all considered for analysis, according to the inclusion and exclusion criteria. Some participants suggested that they would use the term 'teenager' rather than 'adolescent' or 'young person' in a Google search and this was therefore used in the search term.

Participants also identified relevant websites that they have accessed when researching information about depression. Two participants stated that they would look to the charity website, but the charity team advised that a specific webpage for depression could not be identified (see Appendix N).

## **2.7. Interviews**

Whilst Willig (2013) states that semi-structured interviews are an appropriate method to understand how a certain population construct a topic, there are arguments that naturally occurring data is more appropriate for discourse analysis methods (Wodak & Meyer, 2015). Such data would include "real world" conversations between adolescents (including recordings of talk or conversations via social media). There are, however, ethical, and practical difficulties in collecting such data, particularly with children, and it is common for discourse analysts to make use of semi-structured interviews instead. SC perspectives suggest that during interviews, both parties are actively constructing meaning (Silverman, 2015). The participant and researcher are therefore expected to have independent agendas that will affect data, which should be considered within the analysis (Potter & Wetherell, 1995). The interview schedule also remained as open as possible to encourage naturally occurring talk whilst remaining relevant to the research question (see Appendix O). Whilst the interview schedule outlined topics for discussion and potential

follow-up questions, there was no order in which the topics needed to be discussed.

Interviews were completed by the primary researcher. All interviews started with an informal ice-breaker discussion that aimed to put participants at ease. Throughout interviews, language was kept open in the researcher's attempt to not introduce their own language and discourses where possible. Closed questions and phrasing which was constitutive of psychological constructs or terminology were avoided unless using participants' own language.

All interviews were transcribed verbatim using Microsoft Teams and later edited for accuracy by the researcher. The interviews were transcribed according to 'Jefferson light' guidelines (Potter & Hepburn, 2005; Appendix P) due to the importance of including specific conventions of speech for any type of discourse analysis (Willig, 2008). Use of the detailed Jefferson guidelines often reduces the clarity of the transcript and draws attention away from the topic without benefit (Willig, 2008; Smith et al., 2005).

## **2.8. Data Analysis**

Familiarisation with data began prior to analysis, as the primary researcher completed and transcribed all interviews and collated websites. Reading through the interview transcripts whilst listening to recordings enabled consideration of aspects of participants' speech, such as intonation and emphases. Reading through both website and interview data then enabled the researcher to experience the discursive effects of the text, which were noted (see Appendix Q). All data was then then read through twice more, once noting discursive devices that resulted in the texts, with a DP focus, and again with an FDA focus. The analysis of the first transcript was complete before the last participants' interview was transcribed, and before websites were identified and read through. A final stage of the analysis included writing up the findings, although it is argued that a reader's evaluation of the researcher's interpretation is also an important stage of analysis (Potter, 1996). Stages were not always followed linearly, although often each stage opened the possibility to explore the next one.



Websites were analysed following the same guidelines as interviews. However, results were organised to prioritise participants' discourses, to prevent dismissal of these in favour of dominant discourses. Website data was therefore used to contextualise adolescents' conceptualisations within the dominant discourses around them.

## **2.9. Expert Involvement**

Involvement of experts by experience was considered throughout the study. A mental health research charity advertised a request for input in the development of the project on its Young People's Advisory Group. This included identifying appropriate online platforms for recruitment and feedback on the interview schedule. However, no individuals volunteered for this. The University of Nottingham PPI Officer for Children and Young People's Mental Health was also contacted for support. However, this PPI group was in a process of transition and, as such, had no members who reflected the age range of the study at that point in time and was therefore not appropriate to use. Recruitment platforms therefore remained the charities already identified and social media. The interview schedule was reviewed and refined by the researcher and supervisors.

## **2.10. Quality Monitoring**

Replication, consistency, and generalisability are deemed to be irrelevant to monitoring the quality of qualitative research, unlike quantitative research (Finlay, 2006). Alternative measures of quality should be therefore considered in qualitative research, such as credibility and rigour (Spencer & Ritchie, 2012). Numerous steps were therefore taken to monitor quality of the research project from initial conception. The process of analysis has been shown, with extracts of raw data and subsequent analysis presented (Appendix Q). Supervision was held regularly between the primary researcher and three academic supervisors. Supervision logs were completed and maintained by the University of Nottingham to accurately summarise discussions. Research journals were also kept by the primary researcher to note important discussions, thoughts, reflections, and decision-making throughout the project.

The Joanna Briggs Institute (JBI) Checklist for Qualitative Research was also used to assess the quality of the research paper (JBI, 2020; see Appendix R). Given the likelihood of the researcher viewing their project with a positive bias, an independent researcher with experience of qualitative research also completed a checklist (see Appendix S).

### **2.11. Dissemination of Results**

Results of the study will be disseminated in various ways. The shorter journal paper will be submitted for publication in a peer-reviewed journal. All participants requested a copy of the results once the research was complete; a participant-friendly report will therefore be created and shared with participants. Charities that supported with recruitment have also requested a copy of the findings. The findings will also aim to be presented to NHS CAMHS where possible. An appropriate report will therefore be created to be shared with NHS services and charities.

To ensure that the results of the study are disseminated as successfully as possible, key PPI stakeholders will be involved in sharing the results. Participants, and the charities involved with recruitment, will be asked to share the study results with relevant social media groups. Where findings are shared with NHS CAMHS, they will be asked to share the results with other relevant professionals. This will enable the results to be shared with as many people and services as possible who may be interested in, and benefit from, the new findings and implications of these.

## **3. Extended Results**

This analysis presents one interpretation of the data. Table 4 provides contextual information about participants. Table 5 provides contextual information about websites. Some websites acknowledged the systemic impact on caregivers of their child experiencing depression and encouraged them to look after themselves. However, the impact of wider systems was not mentioned in relation to adolescents' experiences of depression by websites beyond brief mentions of discrimination (see *results* section in journal paper and

3.3.i positioned as different). Participants did not consider the systemic impact of their experiences of depression, despite using a social and relational discourse in their conceptualisations of depression.

**Table 4**

*Contextual and demographic participant information*

Pseudonym	Age	Gender identity†	Contact with CAMHS?	Format and length of interview
Sinead	17	Female	No	Audio call 1hr 2 min
Sophie	16	Female	Referred but declined	Video call 1hr 23 min
Charlie	17	Non-binary	Yes	Audio call 1hr 17 min
Fraser	13	Male	Yes – first appointment soon	Audio call 1 hr
Alice	17	Female	No – GP said wait was too long	Audio call 58 mins
Laura	17	Female	No – did not meet criteria	Video call 1 hr 32 min
Ceara	17	Female	No	Audio call 1 hr 5 mins
Jodie	17	Female	No – due to age	Audio call 1 hr 17 mins
Alex	16	Non-binary (born a girl)	Yes	Chat 1 hr 15 mins
Riya	16	Female	Yes	Video call 45 mins Follow-up email
Emma	17	Girl	No – wait was too long	Chat 1 hr 45 mins
Millie	16	Female	Referred but declined	Chat

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*Note: † Verbatim terms from interviews that participants used to identify their gender*

**Table 5***Website contextual information*

Website	Title of website	Identified by	Publication date
The Mix	What is depression?	Google	Updated 16.06.2020
Mayo Clinic	Teen depression	Participants and Google	12.08.2022
YoungMinds	What is depression?	Google	16.02.2018
Relate	Teen depression	Google	
NHS	Depression in children and young people	Participants and Google	16.05.2023
Child Mind Institute	What to do if you think your teenager is depressed	Google	Updated 25.01.2023
WebMD	Teen depression	Google	24.04.2022
Helpguide	Parent's guide to teen depression	Google	Updated 21.06.2023
Childline	Depression	Participants and Google	18.07.2016
Mind	Depression	Participants	04.2023

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**3.1 Discursive devices**

Potter and Wetherell (1987) define interpretative repertoires as the terms and metaphors used to provide patterns of talk in which lived ideologies are maintained. Lived ideologies can be understood as the taken for granted truths which construct versions of reality and allows these repertoires to be used in everyday social interactions (Billig et al., 1988). Interpretative repertoires are suggested to be used by the speakers either consciously or unconsciously to manage social interaction. For the DP aspect of this research, it is useful to

consider discursive devices that have been previously identified by existing literature and have therefore informed analysis. Some interpretative repertoires are outlined below, but there is no definitive list of devices as their function can differ depending on context.

Data collected differed depending on the format in which it took place, including discursive devices used. For example, interviews that took place over chat could not identify discursive devices such as laughter and this therefore could not be included within the analysis. Pauses also could not be identified as any gaps in chat could be a result of the participant typing their answers.

Rhetorical devices, such as metaphors, fence-sitting accounts, lists, repetition, and extreme case formulation, were used throughout the data, and are suggested to play a role in persuading others to agree and marginalising alternative viewpoints (Lukes, 1974). Use of second-person perspective ('you') and neutral third person perspective ('it') were also identified throughout the data, as was the use of laughter, and all were considered important for the interpretation of the data. All of these are outlined below.

Metaphors draw on experiential and emotional concepts to describe a subjective experience that may otherwise be difficult to describe, in terms of another, perhaps better known, experience. As such, metaphors can strengthen an argument by making an experience understandable for others (Lakoff & Johnson, 1980). Lists are a rhetoric device commonly used to strengthen an argument. Lists of three are often used in advertising to provide a sense of completeness (Atkinson, 1984), and lists of five are argued to construct factual accounts (Edwards & Potter, 1992). Similarly, repetition has been found to play a role in increasing the persuasive power of a message (Cacioppo & Petty, 1979).

Fence-sitting accounts were used by both websites and participants. Whilst websites used tentative language such as "can" and "may", participants often caveated their statements with use of the term "I think". Fence-sitting accounts therefore maintain dominant constructions, by protecting arguments from

criticism (Billig, 1988). These accounts have been argued to marginalise alternative constructions, therefore maintaining the dominant medical construction of mental health problems (Harper, 1994). Conversely, extreme case formulation, whereby the extreme limits of the discursive object are presented, such as “all the time” or “never”, can be used to legitimise a claim (Pomerantz, 1986). This is suggested to occur in three potential ways: to defend against challenges; to portray a concept as objective, rather than subjective; and to claim that a behaviour is not wrong due to the frequency with which it is done (Pomerantz, 1986).

Laughter was another device frequently used, which is suggested to have differing discursive roles depending on the context (Grønnerød, 2004): problem revelation; impression management; problems in interaction. Problem revelation occurs where an individual’s laughter presents a contraction between their ideals and their reality, a basic semantic opposition which is present in humour (Raskin, 1985). For instance, patients have been found to laugh where their self-image of being a “good patient” was at stake (Haakana, 1999). Laughter as impression management occurs when an individual laughs alone to soften utterances or behaviour as socially improper, for example job applicants have been found to combine self-praise with laughter as a means of demonstrating their competence without coming across as self-centred (Adelswärd, 1988). Laughter can also be used during problematic interactions to maintain contact, for example where differing agendas become apparently in research interviews (Grønnerød, 2004).

Second person-perspectives, such as the use of the personal pronouns “you”, may not refer to the person addressed (Holmes et al., 1998). This creates referential ambiguity and could be used to offer expert advice to the reader or listener (Dam, 2015), or could be used to generalise an experience to a group of co-participants, or an unspecified group (Mildorf, 2012). Neutral third-person pronouns, such as “it”, can also be used to make an undefined reference to something, keeping the claim vague but still treating it as ‘real’ (Wiggins, 2017).

### **3.2 Medical discourse assumed but doubted**

Both websites and participants use medical language throughout such as “treatment” (websites), “symptoms” (both), and referred to depression as “it” (participants), treating the concept of depression as real (Wiggins, 2017). Websites also assumed the medicalisation of adolescents’ experiences, encouraging parents to seek medical help: “if you think your child is depressed, or you're concerned about their general wellbeing, make an appointment with them to see a GP” (NHS).

This could indicate that parents are encouraged by wider systems to medicalise their children’s experiences of depression, therefore maintaining the medical discourse and depression being treated as an objective concept. However, whilst websites medicalise help-seeking for adolescents experiencing depression, a medical approach to “treatment” is not advocated for. Helpguide mentions the “red flags” of medication for adolescents experiencing depression. This website also acknowledges that the medical model may not be the appropriate dominant narrative, but highlights potential reasons why other narratives may be marginalised: “unfortunately, some parents feel pushed into choosing antidepressant medication over other treatments that may be cost-prohibitive or time intensive” (Helpguide).

This emphasises that medication may be constructed as the easy, quick and cheap option by medical professionals, and that parents may lack power to challenge them. Psychological approaches appear to be less recommended, although this is at odds with websites’ perspectives generally. For example, WebMD details the risks of adolescents taking antidepressant medication, and Child Mind Institute assumes “treatment” to be more psychological approaches:

The [Food and Drug Administration] warns that antidepressant medications can, rarely, increase the risk of suicidal thinking and behavior in children and adolescents with depression and other psychiatric disorders. Use of antidepressants in younger patients, therefore, requires especially close monitoring and follow-up by the treating doctor. If you have questions or concerns, discuss them with your health care provider. (WebMD)

Getting depressed teens into treatment can be tricky. If your child doesn't want to go, be patient and persistent. Give them space, and let them know you're there when they're ready. When your teen is ready, let them choose a therapist they connect with. Make sure that whoever they decide on practices a therapy that works well for depression. Interpersonal therapy (IPT), cognitive behavioral therapy (CBT), and dialectical behavioral therapy (DBT) are often good choices. Many teens with depression also benefit from medication. (Child Mind Institute)

Here, Child Mind Institute presents medication as an afterthought, and does not detail different types, or other aspects to contemplate. Although websites appear to use medical language, medical approaches are marginalised in favour of more psychological discourses. This is also reflected in participants' talk, and Sinead (p. 15) explicitly voices her uncertainty about agreeing with medical explanations:

Sinead: I heard someone talking about a chemical imbalance which I was a bit like (.) ↑mm about I was like I don't really get that I think .hh I don't really understand that theory (.) I'm not sure if it's true or not

Interviewer: tell me- tell me more about that (.) Why-why didn't you get it or agree with it?

Sinead: I just-I'm not sure if we can really put down a whole pattern of behaviour .hh (.) down to (.) someones chemical imbalance because that kind of implies that like they were born with (.) depression and I'm not sure if (.) well I don't -personally think you can be born with depression I think it's the events that happen in your life that can (.) make you feel like that

Whilst Sinead provides her opinions, she keeps this personal with the use of first-person pronouns. Sinead also uses tentative language throughout, suggesting that whilst she feels able to personalise her claims, she does not feel that she has the expertise to generalise these experiences further. Sinead's



out-breath at that point within the statement suggests that she seems to have spent time deliberating over these thoughts, and a sense of exasperation. Both the medical discourse, and the alternative, more psychological explanation that Sinead refers to, however, position power similarly. Whilst medical explanations suggest biological causes within which individuals are unable to control, Sinead also suggests that there is a lack of power in the alternative life events that happen and can lead to depression. Alex (p. 1) further describes their rejection of a medical professional's opinion:

Interviewer: Could you tell me about when you first thought you were experiencing depression? How did you know?

Alex: around july when i was in hospital and the mental health person said i was suffering from depression

Interviewer: what did you think when they said that? Had you noticed that too?

Alex: i denied it and said they were lying

Interviewer: what made you feel that way?

Alex: i dont know

Interviewer: ah ok, did you notice any symptoms or signs of depression yourself?

Alex: no not really

Alex's use of the words "deny" and "lying" suggest that they are positioning their perspective as the correct one, which others are not accepting of, and in doing so rejecting the dominant medical narrative being projected onto them. Alex has been given the language relating to depression, as they had not noticed anything that was suggestive of depression prior to this conversation. However, Alex's challenge of this perspective still positions the medical model as dominant or assumed. Alex further uses discursive devices to shut the conversation down towards the end of this extract. Whilst these comments could insinuate that they do not want to have this conversation, it could also suggest their lack of power to access explanations relating to the questions they were being asked.

Emma (p. 2) similarly described a sense of conflict between how she was feeling, and being told that her experiences indicated that she was in fact experiencing depression:

Emma: maybe i did have something the matter with me ... a lot of my symptoms that i was having i thought were completely normal for kids my age at the time until then so it hit me like a ton of bricks

Interviewer: ahh okay what sort of symptoms do you mean?

Emma: a few i can probably name in particular is when i stopped wanting to take care of myself, not wanting to get up, losing energy to want to do absolutely anything, i did start having suicidal ideation pretty early on actually (that i didnt actually act on) and along with it i started getting heavier anxiety symptoms too i started to fall behind in a few of my classes too because i couldnt concentrate on them

Interviewer: how/when did you realise that these were symptoms of depression?

Emma: my parents made me go to a doctor because i kept denying that it was or that it was related but they were the ones to point it out and thats when i was made to have a big discussion about it and how it might be affecting me

Interviewer: ahh okay and how did it feel when that happened for you and you sort of realised?

Emma: i didnt really believe it to be affectng me as much as i did to be completely honest, i thought i was functioning fine and maybe i did get some bad days but it didnt feel like a sort of real thing depression felt like something really common that i didnt have to take seriously for myself because of that

Here, Emma uses the word “symptoms” to describe her experiences of being a teenager, then goes on to describe an accurate medical description of depression. Emma’s use of “I did” when she describes her experience of suicidal ideation gives a sense of her expressing a list of these symptoms. This also has a somewhat persuasive power, attempting to persuade herself or

others that she is in fact experiencing depression. This could be a routinised discourse that she is re-producing in the interview (Wetherell, 2007), suggesting that it has been well rehearsed in everyday life, due to her need to persuade others about her experience. This, however, is at odds with her description of feeling that she was not experiencing depression, but that she was having ordinary experiences of being a teenager. This suggests that, although this was her initial perspective, her parents medicalising her experiences by taking her to a doctor changed her perspectives about her experiences. It therefore seems that Emma did not hold any power to prevent her parents from medicalising her experiences, and this action then changed how she understood her experience, despite the experiences themselves not having changed.

It is important to note the use of the interviewer's language in this extract. The interviewer asks Emma when she "realised" that she was experiencing depression. This suggests that there was a revelation for Emma to have, indicating that she was wrong to feel like her experiences were "normal" for someone of her age. As always with language, it is important to consider the context this was used in. Emma would not have been taking part in this interview if she did not consider herself to be experiencing depression. Whilst Emma listed a medical description of depression as her experience, it should not have been assumed that she understood this as the medical discourse, and language should have been kept more open, such as "when did you start to feel like your experience did align more with that of depression?".

Conversely to Emma and Alex, Millie appeared to be searching for validation from the medical model when she first started feeling that she might be experiencing depression:

anyway so i used to do all these online quizzes asking the same bloody questions bcs i wanted the screen to tell me i'm depressed and need help and i wanted therapy and i wanted attention and support for so so long (Millie, p. 2)

Whilst Millie feels herself that she is experiencing depression, she does not feel that this is a valid experience until the dominant narratives provide

justification. This suggests that the medical model is reinforced in that she feels unable to access support for her experiences without validation that they are real signs of depression. Jodie (p. 9) also describes a similar experience, as she seeks a diagnosis of depression:

Jodie: I mean I'm very much someone who wants to be given labels I enjoy labels quite a lot so having this idea:: that I can't think of anything that led to it and that I can't even have a -label for it It feels (.) exhaust::ing because I want to relate to all these people around me who were saying a-like how they experience something I relate to (.) but it's kind of like -imposter syndrome I wanna say? I feel like I don't belong in these spaces to talk about my experience

Interviewer: mm w-why is that that you don't feel like=cause obviously you've identified you know coming to me:, and come in to do this project like you've identified as experiencing depression w-why do you feel like you don't belong (.) in that environment?

Jodie: I think it's purely because I've never be-I'm on I'm in therapy, I'm on antidepressants, I'm on all that (.) stuff but I've never been given the label of being depressed I've just been told I am depressed by everyone around me

Interviewer: mm (.) so when you say a label would that be-who would that be from?

Jodie: a: psychiatrist diagnosis of something that would link to depression

Whilst Jodie is seeking a diagnosis for validation of her experiences here, she positions this as a controversial opinion at the very start of the extract, with a sense of defensiveness. Jodie is clearly disempowered here, feeling like an imposter, with connotations that she is not taken seriously and a sense of desperation. There is a sense of conflict that Jodie feels in relation to her identity, feeling that she needs this validation of her experiences of depression to accept this as part of her identity and access validating communities. Jodie also endorses the medical model with the interventions that she is using,

although therapy assumes a more psychological discourse, she is positioning the use of therapy and antidepressants as equally dominant. These are emphasised as being the dominant narrative by the use of a three-part list and the assumption that it is common knowledge by using the term “all that (.) stuff”. Similarly, when discussing recovery, Millie (p. 19) mentions interventions that she has found helpful:

Interviewer: ...what has helped you cope with depression...?

Millie: I think therapy and antidepressants have helped me the most

Millie: well and a bunch of unhealthy things but those are the two which have genuinely helped the most

Millie reinforces these dominant narratives that Jodie also uses, by distinguishing between “healthy” and “unhealthy” interventions, which are assumed as common knowledge. Millie’s initial response to my question reflects the dominant narratives, then on second thoughts, she sends another message, which likely reflect her own beliefs. This suggests that discourses from others are being used here, with a sense of conflict between what she feels like she should say and what she really believes. Riya (p. 1), on the other hand, openly rejects the medical approach to intervention when discussing recovery:

I think nowadays I would say depression is just used as here's a label you're just depressed let's put you on some antidepressants and the-I don't take my antidepressants that=everyone knows that ... but like when I was prescribed I had it once and I never took it again because (.) -firstly I have heard a lot about it making you feel ↑numb (.) and secondly how I feel is you have not done enough to actually say we've done everything before we try and medication (.) you've -not you've-I've been under [mental health service] for (.) less than a year::r are you telling me that it takes less than a year to get a diagnosis of depression and then be put straight on antidepressants? Yes I sort of asked but I think (.) it's like I sort of said it as in like would that help? And he said yeah and prescribed it it's like actually have you talked about what that's gonna do for

me how that's actually gonna affect me a::nd ... I think (.) why don't you help me manage it rather than (.) °give me° drugs?

Throughout this extract, Riya makes use of rhetorical questions, which discursively are used to reinforce common sense, therefore suggesting that her criticisms are commonplace. Riya endorses guidelines for support for adolescents with depression (NICE, 2019), that medication should be the last resort once other avenues have been explored such as psychological therapies. Riya, however, criticises the services' use of these guidelines, positioning herself as an expert. There is a small lapse in Riya's expertise and blame on the service, where she blames herself "yes I sort of asked" then quickly reverts to blaming the service for not listening to what her request was, to discuss the benefits and disadvantages of medication. Riya uses a psychological discourse to criticise her experience of being prescribed antidepressants, rather than things being done *to* her, she seeks a more collaborative approach. The timescales Riya refers to for a diagnosis of depression and prescription of antidepressants also indicates that she endorses the idea that diagnosis should be a process rather than an event.

### **3.3 Disempowerment through relationships**

Emma (p. 1) describes how when she first started thinking that she might be experiencing depression, her primary concern was related to others:

growing up i never really questioned anything related to mental health, i never even knew it was a problem with people until i started dealing with my friends problems and then i started to think about how they applied to me and made a few realisations about myself (that were maybe a little harsh at the time) not fitting in and how i might actually be impacting others and it made me more socially aware that maybe i did have something the matter with me that people wouldnt like

Towards the end of this extract, Emma reiterates the social aspects of her experiences of depression, explicitly describing an increased social awareness. This suggests that the social context she is in holds the power, as she begins to

feel that her experiences are a problem for others. Emma does not mention the impact on herself, suggesting that her experience of depression existed in the context of relationships with others.

### **3.3.i Positioned as different**

Fraser: yeah (.) and then also what I have to say about depression is that some of the things that are causes are or things that gonna impact you in life long so it's not it's not gonna be something that could like resolve in one da:y something that might impact you (.) quite severely in your -life

Interviewer: what kind of things do you mean (.) Fraser?

Fraser: so (.) so some people-so I'd say (.) that some people who have depression will get depression cause for example someone who has died in their family and that is lifelong cause (.) you won't see them again (.) stuff like that or gaining like a medical diagnosis or something (.) that's lifelong

Interviewer: mm (.) yeah

Fraser: For example some people who:: get diagnosed with cancer do normally get depression from what I've (.) heard so

Interviewer: so is that com-is that like something that you you're relating to this kind of diagnosis [neurodiversity] for yourself as well?

Fraser: yeah (.) yeah

Interviewer: in what way do you think that impacts kind of (.) depression?

Fraser: u:m it's just because I think cause normally I thought it was normal then to be told tha::t and so I'm not gonna be normal for the rest of my life and some opportunities that I had before (.) I won't be able to achieve anymore (.) which::: and also and also some and also now I know that also some that I have a high possibility of being discriminated for the rest of my life (.) and and because of that I thought there was no (.) point of living anymore

Here, Fraser (p. 9) discusses the future, and suggests that recovery is not easy, with a neurodiversity diagnosis, and subsequently depression, having a life-long impact on him. Whilst Fraser begins by positioning this statement as his own opinion and experience, he then makes use of a second-person perspective, assuming that his experience is a common one, and therefore protecting himself from accountability and responsibility for this statement. In doing this, he also appears to position himself as an expert who is providing advice, which further highlights the assumed commonality of this experience.

Further to this, the extract from Fraser's interview here draws upon a social discourse of disability. This indicates that less power is available for individuals for whom the world views as disabled, as systems are tailored towards those who are 'able'. This further brings into question how 'normality' is defined and by whom, as Fraser appears to lack power to challenge this definition. Fraser instead seems to try and find other ways to hold power. Fraser describes these processes of social power leading to him feeling an ultimate sense of hopelessness. Suicidal ideation could be his attempt to gain some power over a body or a brain that is not considered 'normal'.

Laura (p. 27) also assumes that her experience of depression was caused by social processes which led to her feeling outcast and "weird", including bullying, which she talks about throughout her interview. She however further goes on to describe her perspective:

I-I've got coping mechanisms when things become too much like it it's getting better it's still there but it's more-it's more just an anger all these people rather than it being internalised oh I'm angry at these people for to ((inaudible)) you know using (.) my vulnerability um and my own state for their own gains essentially rather than being angry at myself for-being angry at myself for like getting-like being traumatised by all these people like it's more like at other people than I am at myself and that I think (.) is like the first step of recovery because I'm not I'm not I'm not upset at myself like I don't you know I-I recognise I've done nothing wrong and it's these other people (.) but I think it's kind of (.) the next step is just dunno



(.) kind of -forgiving them which (.) I mean I haven't completely done so far but I can't even (.) like I still I still look at like my parents and then the school teachers and stuff with contempt (.) for making me feel like that so (.) °that will come in time°

Whilst Laura locates the cause of her experience of depression socially, in relational processes, she positions recovery as an internal process. Instead of blaming herself for letting others take advantage of her, her perceptions of these social processes begin to change. Unlike Fraser, therefore, it seems that Laura has gained some power to be able to change her social position to a more empowered one, even if this is a slow process. Laura (p. 26) appears to attribute her empowerment being diagnosed with Autism:

it's helped me personally make sense of things but at the same time it's also made me like I -think maybe feel sad but in a different way like it's not I'm depressed anymore it's-I'm angry like I-I'm angry-you know

This suggests that, a diagnosis played a social role for Laura, being able to re-evaluate events in her life. Although this was a neurodiversity diagnosis rather than one of depression, Laura views this change in her perceptions of her experiences in playing a key role in the first step of her recovery from depression.

Whilst both Laura and Fraser discuss feeling different due to their neurodiversity playing a role in their experience of depression, Jodie (p. 4) discusses feeling outcast for different reasons:

Jodie: oh:: it was horrible I remember I had a nickname growing up and that was called Moaner because I used to complain about every single little thing and I would find bad-negatives in everything around me and that was horrible to grow up with cause I didn't want to do it but I just somehow did it every single time so I stopped speaking for a little bit as well to try and calm? it -down... I think in the long run it... kind of (.) shifted? who I became and made me less sociable:, it made me ... feel more isolated than

everyone else... um (.) it made it very hard to have (.) friends especially when I was developing (.) I didn't learn the social cues everyone else learnt, I didn't u::h I guess socially I didn't develop in the same way as everyone else

Interviewer: mm and (.) well yeah tell me-tell me a bit more about that-what do you mean by not socially developing?

Jodie: I mean everyone else was maki-everyone else was making all these friends really easily:: especially in secondary school everyone was easily able to have conversations with people whereas... the -only people I could really talk to was adults?... I-I felt cause I didn't wanna hang out with my own age group coz I didn't understand how to hang out with them um (.) that made me develop the language that adults would use and so that would outcast me even more (.) to my peers... I didn't want to leave the classroom so I would instead stay with the teacher

Interviewer: yeah and like w-why-I guess it comes back around but like why would you want to: stay in the classroom?

Jodie: ca(h)use I felt isolated from my peers and didn't didn't I think I was afra::id to communicate with them but I didn't want to be bullied for something that (.) wasn't really my fault

Interviewer: yeah a-and this like social development Jodie and all like I think you've just been describing h-how do you see that that kind of relates to depression in that experience?

Jodie: because I feel like the depression is what triggered it the m-my negative thoughts... and just me not wanting to go out and do anything (.) that didn't allow me to go out and do the same things that my -friends were doing and so we didn't form a close bond because I (.) didn't want to do those things

Jodie does not appear to hold much power in these circumstances, for instance the only action available to Jodie from those who gave her the nickname was to stop talking and therefore disconnect from others. The disconnection and isolation then increased Jodie's sense of being different, which ultimately perpetuated her depression. Further to this, Jodie's

disempowerment is evident as she views her friends as “right” and herself as “wrong” for not wanting to do the same things as her friends. Whilst she does not provide context of what these “things” are, Jodie pulls the reader in to her position as the outcast. It’s also interesting that she positions these peers as friends although feeling a sense of disconnect from them and feeling like the outcast. This perhaps reflects the complex social dynamics that occur during the social reorganisation of adolescence.

Websites did not focus on how feeling different, or outcast, could play a role in, or characterise adolescents’ experiences of depression further than a mention of discrimination (YoungMinds, Mayo Clinic). This suggests that this is not a dominant narrative.

### **3.3.ii From isolation to connection**

I think it's (.) because I was-I felt isolated after [relationship breakdown] and being-feeling abandoned or isolated has usually triggered some kind of depression for me (.) like why I was depressed during lock down because I was alone (.) like all of the time (.) (Sinead, p. 12)

Here, Sinead uses extreme case formulation, a discursive device with a persuasive purpose, to further emphasise the role of isolation in her experience of depression and her lack of power within this process. Ceara (p. 2) locates herself as having a more active role in isolation:

I just felt like (.) nothing really like mattered it was just me and I was just all alone with my thoughts and no one really understood them (.) and that's why I didn't really socialise like with um people because I just thought that they (.) wouldn't understand and it made me like really isolate myself from others

Ceara uses extreme case formulation throughout this description of her isolation, such as “nothing”, “all alone” and “no one”, emphasising that her thoughts were her only company. Combined with her use of the three-part list (Jefferson, 1990), she is emphasising that the only action available to her was

to isolate herself. Therefore, whilst she takes an active role in isolating herself, it was not a choice but something she was “made” to do by not feeling understood by others. Ceara therefore, similarly to Sinead, was also powerless in her isolation. The Helpguide website describes the role of isolation in adolescent depression, and how social media can exacerbate this. Helpguide therefore assumes that the use of social media is an isolating experience, rather than one that promotes a sense of connection. Helpguide also states the actions that adolescents can take to overcome the isolation: “the simple act of connecting face to face can play a big role in reducing your teen's depression”.

This contrasts to Ceara’s experience of depression, where she felt misunderstood by others which led her to isolate herself. Positioning face-to-face connection as “simple” does not consider adolescents’ experiences and could be shaming for adolescents. With Helpguide aimed at caregivers, they could pass this narrative down to their adolescent, which could lead the adolescent to feel even more misunderstood. This, certainly for Ceara, would lead to further self-isolation and perhaps a worsening in their experience of depression. Sinead agrees with Helpguide, with gaining connection with others as a “coping strategy” for her experience of depression, although this must be meaningful and with “people who care about me and I care about”. Alice also aims for a sense of connection with others as she aims for recovery. However, as Alice (p. 26-27) begins to talk about how she views the role of connection playing a part in her recovery, she is then cut off by being asked another question:

Interviewer: how would you know maybe you -got there or what would-what would it mean to you?

Alice: um (.) I guess just like not feeling those low moods like (3.5) ... so like not feeling like low while like socialising stuff and feeling fully there and then also like being able to manage everything that goes on in life and stuff

Interviewer: mm (.) so you meant like like not when you were socialising and you don't feel like you fully there because you're somewhere else (.) that would be different

Alice: Yeah

Interviewer: yeah um (.) ho--how do you think like that would be different? Like how do you think you'd get there or what have you thought about in terms of aiming towards that Alice?

Alice: um (.) just (.) I don't know (.) um just just like-

Interviewer: I mean things like what about support and for maybe like like obviously you said about counselling or what would-what would help in in terms of that kind of side of thing?

It seems that, in the moment, "I don't know" is interpreted as Alice not knowing the answer, but it could also be representative of a thought process, particularly if it is something she has not thought about previously. Further to this, she is asked two different questions at the same time, so it is likely that she is processing these questions to formulate an answer. A power imbalance is clear in this extract, as the interviewer leads the conversation in their direction, with Alice following.

YoungMinds took a more open approach to describing how isolation and connection can play a role: "it's very easy with depression to feel like you're experiencing it alone, but depression tends to thrive on someone being isolated. It can be extremely useful to reach out and talk to someone about what you're feeling". Whilst YoungMinds use open and tentative language, leaving room for alternative viewpoints, depression is also positioned as the "other", in a conflict with the "self". This suggests that adolescents could also experience their depression as something separate from the self, with both having different goals. This can also be seen in the way that participants refer to their experience of depression as "it". Sometimes the conflict between 'the depression' and the 'self' is negative, for example Millie (p. 12) blames herself for allowing 'the depression' to take hold: "maybe i wasn't fighting the monster hard enough initially but then it got to the point where it wasn't my fault bcs i just had to let it take over". Here, Millie positions 'the depression' as holding the power and herself as having no choice but to control her. Millie uses a battle discourse to describe her relationship with 'the depression', insinuating that this is not a straightforward relationship. Other times, however, the relationship with 'the depression' can be more positive, such as Jodie's use of the medical

discourse to seek a diagnosis, enabling her to accept it as a part of her identity and feel able to access supportive communities.

### **3.4 Physical embodiment is a marginalised narrative**

Separating a phenomenon between a mental and physical experience is in itself drawing upon a mind/body dualism discourse which has come to be assumed as common sense.

When directly asked “how would you describe depression?”, a narrative of embodiment dominated participants’ answers, in the sense of experiencing depression in this way. Laura (p. 9) demonstrates this:

Interviewer: if someone asks like wha-what was it like? Like how would you describe -it?

Laura: I think just this like (.) it's not like I mean I think physically I felt like heavy in my chest like all the time like it felt like (.) dunno (.) like I was one of those people that was just carrying a massive boulder like in their chest and (.) it was like you couldn't-you couldn't shift it you know like I felt like it like I mean any positive (.) thing which I mean I did you know I did experience on days that were quite positive that people would (.) as they ((inaudible)) or I got a good grade in a maths test or whatever but it was like just you-you'd feel that like positive-positivity for like 5 minutes and then it would just absorb into this big boulder of depression and then it would take over your entire head and (.) you know I just felt heavy and groggy and just rubbish all the time and I think it got to the-yeah I think with me it got to the point where I'd be like the only thing I could do to get that like (.) 5 minutes of release was like you know cut myself or whatever um (.) and it would be like ohh you know (.) so I just describe it as this massive boulder in in your chest that's like it's just heavy and it's there and you can't do anything to get rid of it no matter how hard you try, no matter how much you go to counselling, you do this, you do that, like it's always just (.) there

Laura's inclusive terms throughout this extract ("you know") demonstrate her attempt to normalise this experience, inviting the interviewer to also take her perspective. She also positions the act of carrying a boulder in a way in which assumes that individuals experiencing depression will all be subject to, with use of the term "one of those people". Laura's example of a positive experience being a good grade at school is suggestive of others' discourses being adopted here. If this is others' markers of positivity, rather than her own, then it is less likely to have a lasting positive effect on her mood. Potentially being unable to apply her own markers of positivity suggests a lack of power compared to the system around her such as schoolteachers and her parents, and the dominant narrative of positive academic achievement during adolescence. Laura further shows a lack of power in her attempts to experience positivity throughout this extract, with the only action available being self-harm. Laura only talks briefly about self-harm and does not finish her sentence, which could indicate that she is drawing upon the stigmatising narrative relating to self-harm. However, she immediately goes back to describe the boulder in her chest, which could reflect how difficult it is to find the relief, but how easy it is to feel the boulder.

Sophie (p. 9) also described the heaviness of depression, using a metaphor in which she is given a bag of rocks that she must carry around which keeps getting heavier and begins to impact on her life:

Interviewer: Yeah (.) so:: can I ask Sophie what (.) like (.) how would you describe depression then?

(5)

Interviewer: sorry (.) it's a big question

Sophie: It's:: it sounds really cliché, but it's like (2.5) u::m (.) everybody is going (.) about their lives and they're all like (3) um (.) you know (.) just=>-everybody goes about their lives< (.) and (.) one day you're handed like a bag .hh and (.) that bag has (.) like (.) >I dunno< a rock in it .hh and you have to carry that bag around everywhere (.) and then gradually they're just like more and more rocks in this bag- and eventually you're just like dra::gg:ing this bag everywhere you go and it makes it very hard to (.) like (1.5)

just (.) get on with your -life? If you have to take this -bag  
everywhere that's full [of -rocks ]

Sophie (p. 1) took many long pauses and towards the beginning of her interview provided a disclaimer that it sometimes takes “my brain a minute to think” which could indicate that she has previously felt judged for this. Her long pause after the question, however, indicates that she did spend time formulating her answer and therefore suggest that this is not a pre-rehearsed narrative that she finds herself drawing upon in many conversations. However, Sophie also describes this as a cliché, in doing so positioning the heaviness of depression as a common experience, and dominant narrative. This metaphor is suggestive of the lack of power Sophie holds in her experience of depression, as the bag is handed to her and she doesn't appear to have a choice to refuse taking it. Further to this, the use of second-person pronouns indicates the commonality of this experience for individuals experiencing depression.

Similarly to Laura and Sophie, Jodie describes her experience of depression being akin to swimming with clothes on, whereby the clothes are the experience of depression itself and are making her powerless to accessing happiness (being above the water), by weighing her down. Millie (p. 11) also describes depression using metaphors:

Interviewer: how else would you describe depression? like if you had to explain it to someone who'd never experienced it

Millie: it's basically every single cringy analogy like drowning or being under a big fat raincloud or being trapped in your mind like it's a prison or being in a big black empty dark chamber or in a tunnel/maze with no way out

i used to think of it as like a big hole i began digging and i fell inside and people would put their hand down to try and help me but i kept digging the hole until i went so far down underground away from the sun and light and others that no ladder or rope could help me ever get out



Framing her description in this way also assumes that these are dominant narratives, distancing herself from their authorship but also endorsing them. Millie also describes a sense of self-blame, whereby she did not take the help that was offered to her by others, but then became so deep in the hole that she then could not be reached. This suggests that whilst she felt she played a role in being in such a deep hole, she has no power that she can use to move towards recovery, out of the hole.

Websites also draw upon the mind/body dualism discourse, although depression is framed as causing these physical experiences, rather than comprising of them: “Signs of depression can be: ...; tiredness or low energy, even when you have rested; changes in how much you’re eating; aches or pains that have no obvious cause” (Childline).

In discussing recovery, websites also drew on narratives of the distinction between the mind and body, emphasising the importance of physical activity. How or why physical activity might help someone who is experiencing depression, however, is not expanded on: “how do I cope with depression? ...; Get some exercise: try to find something active that you enjoy and start small, maybe a 20-minute jog, then build up to a longer routine” (The Mix).

This suggests that this process is a slow one, rather than a quick-fix, and similarly to Emma’s description of climbing mount Everest, requires effort and commitment from the individual. However, how this is framed by the website could be shaming for the audience reading it, assuming that a 20-minute jog would be considered as small by adolescents, and that they would find this enjoyable. Adolescents who are looking at this website and may therefore already feel that they are experiencing depression, may also be experiencing the heaviness as described by participants. This heaviness could therefore represent a barrier to physical activity and is also likely to make a 20-minute jog feel much harder than is being suggested. Whilst the website attempts to be tentative with the use of words “try” and “maybe”, this is not the overarching effect of the statement on the reader. This could be due to the three-part list used, which can have persuasive effects (Jefferson, 1990).

Websites, instead, often drew upon cognitive-behavioural discourses in their descriptions of depression, as can be seen in the Mayo Clinic extract above, and on the WebMD website: “often, kids with teen depression will have a noticeable change in their thinking and behaviour”.

This description emphasises that these changes are noticeable but does not indicate whether they are noticeable internally (for the individual) or externally (for others), although behaviours may be assumed as being noticeable by others. The Mayo Clinic website aims its information at parents/carers of adolescents experiencing depression, helping them to understand what teenagers may experience during depression: “teen depression is a serious mental health problem that causes a persistent feeling of sadness and loss of interest in activities. It affects how your teenager thinks, feels and behaves, and it can cause emotional, functional and physical problems”. Whilst this description draws on, and endorses, the medical narrative, framing depression as causing (rather than being made up of) these experiences, it also draws on a cognitive-behavioural narratives. This suggests the lack of power that adolescence have, that if they ‘get’ depression, they will have no role in the onset of these internal and external experiences.

The Mix uses tentative language here, with the use of the word “may”, however, a definitive list of “signs” is still provided:

You may have noticed a change in the way you’re responding or feeling about things. The following points can be signs of depression:

- Persistent sadness, lasting two weeks or more
- Loss of interest in your favourite things
- Finding no fun or enjoyment in life
- Loss of self-confidence
- Feeling guilty, bad, unlikeable or not good enough
- Feeling empty inside
- Feeling useless or unable to cope with life

- Feeling bored all the time
- Increasing feelings of anxiety
- Can't see a future for yourself
- Thinking everything is pointless
- Feeling more irritable, frustrated, or aggressive than usual
- Trouble concentrating on things, poor memory

(The Mix)

This could serve to invalidate experience of adolescents that are not included on the list, including the participants' descriptions of embodiment. Websites therefore seem to marginalise participants' experiences of depression being one of embodiment, instead focussing on cognitive-behavioural narratives and endorsements of the medical model by reiterating diagnostic criteria. The Mix is a charity specifically for young people, so an adolescent reading these might feel marginalised by the dominant narratives if their experiences are not included.

Cognitive-behavioural narratives were sometimes drawn upon by participants. Ceara (p. 12) described an example of how her thoughts and feelings influence her behaviours if she dropped a pen:

if I'm really depressed I would just think like what's the point of picking up other pens if I'm just gonna drop them and and be stupid because I've dropped them and I feel really sad because I did something stupid and I shouldn't have done it but I've done it and it's that feeling that oh because I've dropped that pen once (.) I'm just gonna keep on doing it and I'm just stupid because I've done that and I'm and -a:ll these negative feelings about myself because I've done that (.) rather than actually thinking oh I've dropped the pen once I can just get-I can just pick it -up and actually carry on doing my work but there's that binary (.) that those binary thought that it's either like -alright I can just pick it up

or (.) it's so bad because I've done that so stupid wh-why have you done that? Why did you let yourself do that?

Ceara uses extreme case formulation throughout this extract, which is reflective of the “binary” thought processes she reports experiencing at the time Ceara appears to see herself as all negative and will drop all other pens, strengthening her argument about her defectiveness. Therefore, whilst here the extreme case formulation does strengthen her argument, it also enables the reader to experience what it is like to have those thought processes in depression that she is describing. Throughout this explanation, Ceara is endorsing a cognitive-behavioural narrative, which is assumed throughout her interview, although she does not name it explicitly. This is interesting to consider as Ceara has not accessed CAMHS previously, which suggests that the cognitive-behavioural narrative reaches further than CAMHS and has become unconsciously assumed as common sense for Ceara. At the start of this extract, Ceara is personalising her experiences with the use of the first-person perspective, which further suggests that she is unaware of the dominant narrative she is describing that might be assumed as a generalised experience. However, towards the end of this extract, Ceara begins using the second person. This could either be an acknowledgement of her experiences being more common, or it could be an attempt at creating some emotional distance to her speech, due to the way in which she is engaging in self-blame and the potential emotional impact of this.

Jodie (p. 45) also uses a cognitive-behavioural narrative to describe how she envisions recovery, after discussing her experiences of negative thoughts, including suicidal thoughts:

Interviewer: so what (.) I guess what would recovery (.) like what would be different? Or what would you look to? What would-what would it mean to you?

Jodie: I honestly haven't-like I'm I know I'm never gonna not have these thoughts like I know it's just part of me now (.) but I guess having them less frequently and less um (.) what's the word? Strongly?

Interviewer: mm and why would that help (.) things?

Jodie: I guess because it would allow me to focus on my life rather than focus on (.) like when is this going to happen again, and when am I going to feel like this, instead of-like instead of constantly trying to rush stuff to get it done to prevent it I'm just able to live freely I guess?

Jodie assumes that these thoughts have become a part of her identity as she pictures what recovery may be like for her. This suggests that Jodie first saw her thoughts as a separate entity to herself, but they now have become internalised, and she has learnt to expect them as normal. This suggests an experience different to Ceara's description of binary thoughts, as Jodie can see a grey area where she may not necessarily 'recover' but reach a point where she feels able to manage her experiences because they are less intense. This creates a shift in where the power is held, as Jodie may have increasing opportunities to hold the power when her thoughts are less frequent or strong. Being able to "live freely" is further demonstrative of this, insinuating that she has felt trapped or constrained whilst her thoughts have held the power.

Therefore, whilst both websites and participants draw upon a cognitive-behavioural narrative, this is emphasised more by websites. On the other hand, whilst there is a strong emphasis on participants' experiences of the embodiment of depression, this is not mentioned by websites, which appear to be more reflective of a medical model. This would suggest that experiences of the embodiment of depression are marginalised by dominant discourses.

### **3.5 From dismissed child to responsible adult**

Sophie (p. 16) describes the way in which she sees the world having changed from when she was a child, before she started experiencing depression, to when she started experiencing depression around the age of 13:

Sophie: I think I ↓grew up a lot (2) I think I was like (1.5) oh(h) this (.) like this world that we ↓live in is not the same world that I lived in when I was (.) litt(h)le

Interviewer: mm in what way?

Sophie: (5) um (13) I don't (.) ↓really know? I was just (.) >sorry, that's so unhelpful<

Interviewer: ↑No it's not it's ↑fine

Sophie: It just (.) felt (0.5) like (5) scar(h)ier (.) I guess (.) like (3) um (3) that's a really unhelpful=it felt more -difficult? or (.) like (.) like I guess >you know< the w- (3) when you're younger, you don't really (2.5) .hh I don't think like you think a lot about the world around you and like what's going on in other people's brains and like (.) you don't really have to do anything when you're a child it all gets done for you and then you get older and you're like ↑oh this is harder than I expected? (2)

Interviewer: Yeah, that I-I understand that makes perfect sense so it's like .hh I-do you think like? Mm I need to think how to word this myself now .hh u:m (2) do you think (.) depression like (.) experiencing depression (.) impacted that (1.5) change or (.) that change (.) impacted your depression (.) does that make sense?

Sophie: °Yeah, it does° (.) I ↑think it's a ↑bit of ↓both really um (3.5) some of (2) like the things that you ↓obviously like (.) learn as you grow up (1.5) like that you have to do (.) like chores and stuff (.) and that there's like >you know< you learn about (.) like history:: and (.) like bad stuff that happened in history: (.) .hh and like bad stuff that goes ↑on in the wo::rld (.) and I think some of that definitely made me be like what's the point? u:m but some of- .hh some of it >I think< the way that I saw the world definitely was becau-is because (.) ↓of feeling (.) ↓depressed?

Here, Sophie is describing how the adolescent transition to adulthood reduces the childhood naivety that she is reflecting on, which appeared to protect her from the reality of adulthood and the experience of depression. Sophie's statements are tentative, with the use of "I think" and "I guess", but she also positions these statements as common sense throughout, with the use of "you know" and "obviously". This could be reflective of Sophie's new adjustment

to adulthood, having new access to these explanations and testing them out. Sophie explicitly refers to her transition in responsibilities, becoming less reliant on her caregivers, coming as a shock and contributing to her experience of depression. Sophie's experience of depression aligning with her transition to adulthood could be reflective of her nostalgia or grief for the childhood naivety which appeared to play a protective role in her experience of depression.

Similarly, Sinead (p. 19) describes the "path" to recovery was the difficult path to take. Beforehand, suicidal ideation appeared to protect her from the impending responsibilities of adulthood:

I used to when I've been (.) kind of in more periods of severe depression .hh I used to think I might not-might not be here when I'm an adult so I don't need to worry about it (.) .hhh now that I've kind of gone down (.) like this path of like -essentially recovery to the extent that I am now I'm starting to think oh (.) I am actually going to have to be an adult and (.) get a job and go to uni and like form adult relationships (.) and it just it feels like (.) a lot

Describing the lack of need to worry about adulthood suggests that this is something that she should worry about, emphasising the seriousness of adulthood, and the role this plays in the adolescent transition. Whilst Sinead indicates that recovery brings responsibility with it, Emma (p. 10) positions the recovery process as requiring a sense of maturation in itself:

Emma: honestly for me it took a lot of stepping up to responsibility, i dont really like blaming things on depression even though its definitely a very real thing for me i also like to be independent and manage things myself so maturing my attitude towards it and other things really helped...

Interviewer: ... what do you mean by maturing your attitude towards it?

Emma: for me it was sort of like stepping up to a job, i knew there was a lot of things i needed to improve on regardless of depression and excusing every problem i had with it wasnt going to improve anything - i think a lot of people are anti-recovery too

just because its easier to go through that every day and not make any changes than it is to have to use energy doing new things it can be really scary and overwhelming for people

Emma's use of second person pronouns here is indicative of her giving expert advice, and that she is describing a common experience, emphasised by her positioning it as overwhelming "for people". Further to this, Emma is suggesting that using depression as an excuse is immature, which she then distances herself from, positioning herself as mature and others as less mature. Emma repeatedly emphasises this maturity, using persuasive techniques such as extreme case formulation with use of the terms "honestly" and "definitely". Emma initially describes feeling that her experiences were not depression and just "normal" for her age. It should therefore be questioned how she came to this conclusion of recovery. It seems that she has adopted others' discourses of depression to enable her access to this discourse for recovery.

Alice (p. 23) also described a sense of worry about future responsibilities, as she continues to transition into adulthood, and how depression may impact this:

um (.) does maybe worry me for things like university when it's like (.) um you've got a lot more like independence um (.) and you like and you're probably like have more opportunities to have like social (.) things going on and then you're like you have to like very much more be keeping on top of your own deadlines without like prompts and stuff um and also like maybe like running like (.) a house li(h)ke like if I'm struggling to like keep my own like room and stuff like in order because I'm struggling to get out of bed like how am I supposed to like keep a house in or(h)der but yeah (.) I guess

This suggests that she is expecting the experience of depression as a teenager and as an adult to be different. This was often reflected in the way websites wrote about depression, referring to "*teen depression*" (Helpguide,



Relate, WebMD, Mayo Clinic), therefore positioning it as a different experience to adult depression.

Most websites also draw upon narratives that question the differences between experiences of being a “normal” teenager versus those of depression in adolescence. For example, Mayo Clinic normalises the difficulties that can be experienced during adolescence but compare this what an experience of depression might be like, assuming a medical discourse:

Issues such as peer pressure, academic expectations and changing bodies can bring a lot of ups and downs for teens. But for some teens, the lows are more than just temporary feelings — they're a symptom of depression... It can be difficult to tell the difference between ups and downs that are just part of being a teenager and teen depression

Relate, aiming their website at caregivers, defines which experiences constitute depression rather than adolescence: “bad moods or occasionally feeling sad are normal in young people. When a depressive state or mood lingers for a long time and limits a person's ability to function normally it can be diagnosed as depression”. Relate, a service that provides relationship counselling, including a page about “teen depression” on their website, suggests that this is a common experience that is brought to the service by caregivers.

Alice (p. 15-16) also distinguishes between “normal” aspects of being a teenager and her experience of depression:

Interviewer: but is that kind of the main thing you... think was the cause

Alice: I guess so I guess it's I guess it's more just like (.) I feel like a lot of like (.) normal like hormonal changes as well as like normal like (.) and like changes in self-esteem as a teenager I feel like it got me into that headspace of a lot a lot of negative ↑thinking and like when it's like all the time that's I feel like that's how like it

develops and then you have all the other like life stresses on top and then it gets overwhelming and then it's like oh (.) yeah

Alice appears to hesitate at the beginning, with repeated use of “I guess”, indicating that she is uncertain of her answer to the question. The question came after Alice had described other aspects of her life that she attributed to her experience of depression. The question could therefore have been interpreted by Alice as seeking a “correct” answer, given the inherent power dynamics in the relationship between researcher and participant. The question could have therefore been more open, such as “is there anything we haven’t spoken about already that you feel is relevant?”. Further to this, ending this description of how she feels her teenage experiences led to her feeling that they began to constitute depression in this way suggests Alice’s avoidance of talking about her experiences of depression. This indicates that Alice perhaps finds it easier to describe her experiences of being a teenager, also reinforced by her referring to depression as “it”. Alice positions this as an inclusive experience, rather than a personal one, although uses “I feel” to protect herself from the accountability of these statements.

#### **4. Extended Discussion**

##### **4.2 Medical discourse assumed but doubted**

Participants drew upon medical discourses to conceptualise their experiences of depression and recovery. For example, by acknowledging “healthy” and “unhealthy” interventions or seeking a diagnosis of depression to feel validated for the experiences they were having. This validation from the medical model made participants feel that they were eligible to ask for support. DA, however, is not a cognitivist method and therefore does not assume that language represents internal processes such as attitudes, cognitions and feelings, as psychological theories commonly posit (Alford & Beck, 1994). DA instead suggests that individuals’ talk has numerous functions, with consequences for actions, subject positions, and power (Willig, 2008). Therefore, unlike alternative methods, the use of DA in this study was able to show that participants’ use of medical discourses did not always correspond to

their acceptance of the principles of the medical model of depression and recovery.

Participants' need for medical validation demonstrates how dominant the medical discourses of depression and recovery are; that participants did not feel valid for their experiences, and therefore unable to access support to move towards recovery, until they were told so by the medical model. It therefore appears that adolescents are disempowered in their experiences of depression until they are given the power to talk about it medically, make sense of it in this way, and seek opportunity for recovery. This appears to impact on adolescents' conceptualisations of depression, as when they draw upon their own discourses, they are often dismissed by those around them and rejected by mental health services. Adolescents therefore appear to only be validated for their experiences when conceptualising them medically, and therefore rely upon medical discourses to be understood by others. This could suggest that caregivers, schools, and mental health services are using medical terminology and assuming that adolescents relate to this in the same way. However, participants appeared to conceptualise their experiences of depression differently, and medical discourses therefore act to marginalise adolescents' conceptualisations. As Riya demonstrated, it is likely that adolescents want others, including mental health services to help them understand their experiences, rather than just relieving their 'symptoms' with the use of medication. Participants' experiences therefore suggests that mental health services endorse a medical view of recovery, with a focus on relief from symptoms (Jacob, 2015). However, websites' conceptualisations of recovery appeared to align with the NICE (2019) guidelines for children and young people experiencing depression. These guidelines, and the websites, both emphasise psychological discourses of recovery and highlight the disadvantages of using medical interventions with adolescents (NICE, 2019), also marginalising the medical discourse.

#### **4.3 Disempowerment through relationships**

Due to the importance of social relationships at this age, and adolescents' innate need for social connection, it is perhaps unsurprising that relational

discourses were drawn upon. Whilst adolescents previously placed relational difficulties as a factor that played a role in the onset of their depression (Dundon, 2006), this was prior to the rapid development of social media platforms. Social media increases individuals' access to social relationships and are therefore suggested to play a key role in adolescents' development and social reorganisation (O'Keeffe & Clarke-Pearson, 2011). However, there was little mention of social media in the relational discourses that were drawn upon by participants. This could suggest that social media is so assumed as the mechanism by which these disempowering relational processes take place, that adolescents feel that it does not need naming explicitly. The lack of reference to social media could also suggest that it is not the mechanism by which these relational processes take place that matter, but the relational processes themselves, in any format. Language of face-to-face social interaction is often used, for example Alice describes not feeling "fully there" when she is "socialising" and Sinead describes it being helpful to be "around people". However, in adolescents' sociocultural contexts, it should not be assumed that this language necessarily reflects face-to-face socialising and it could also represent online socialising.

Conversely, websites mentioned the role of social media in exacerbating adolescents' isolation, and face-to-face connection as an easy way to overcome this. However, this is not reflective of adolescents' experience since the COVID-19 pandemic, whereby social media use improved adolescents' social connectedness (Marciano et al., 2022), nor previous findings that adolescents find face-to-face social interaction more difficult to engage in (Martin & Atkinson, 2018). Therefore, even though, for example, the Helpguide website was updated in 2023, this is not necessarily reflective of current adolescents' experiences of social media use and isolation. Dominant perceptions of adolescents' experience of isolation should perhaps be explored in future research, considering the changes in social reorganisation since the rapid increase in social media use and the COVID-19 pandemic.

Adolescents identify social connection as a marker of recovery following isolation during depression, as do websites, reflecting previous findings of the

CHIME framework (Leamy et al., 2011; Naughton et al., 2018). However, it is difficult to distinguish these connections from the relational processes which play a role in the experience of depression initially. If adolescents are disempowered in relational processes in their experiences of depression, then it should be considered how these more positive connections are identified and fostered, to lead to recovery. The disempowerment adolescents experience would indicate that this connection would be initiated by others. Future research could explore how adolescents experience this shift from isolation and disempowerment to connection. Further to this, if adolescents do continue to lack power in seeking connection, then people and systems surrounding adolescents should aim to promote and improve adolescents' opportunities for connections with others. The way in, and ease by, which adolescents do this should not be assumed and it could be empowering for adolescents to have a role in fostering these connections. The role of empowerment in recovery has also been identified by previous research (Leamy et al., 2011).

Adolescents' disempowerment in their experiences of depression was also conceptualised through their experiences of being positioned as different from their peers. In this sense, participants' conceptualisations appear to reflect the SRT of depression (Price et al., 1994). Participants describe how their awareness of losing social status amongst their peers for various reasons led to their experiences of depression. SRT suggests that, in this context, experiences of depression are an evolutionary response to lacking power to challenge a social situation (Sloman, 2000). The social reorganisation and rejection that often takes place during adolescence suggests the evolutionary nature of this response to social threat. This also suggests that experiences understood as depression are not an illness but a natural response to an environmental difficulty. NICE (2019) guidelines suggest the importance of exploring social relationships with adolescents to understand their experiences of depression. However, recommended interventions include CBT and interpersonal therapy for adolescents (NICE, 2019). Whilst these approaches acknowledge the role of an individual's past experiences in their current difficulties, they also place emphasis on the individual as the 'problem' and their individual responsibility to make the changes to move towards recovery (Dalal, 2019). Alternatively, family

therapy approaches are also recommended (NICE, 2019) which may consider wider mechanisms of change, although are unlikely to explore important systems the young person is involved in beyond their family.

Whilst social reorganisation and peer rejection are experiences that are expected during adolescence (Mulvey et al., 2017), the lack of power that adolescents hold within their relationships should be acknowledged. This could help empower adolescents within their relationships, which may address two processes that are suggested to be key for recovery in both adults and adolescents: connectedness and empowerment (Leamy et al., 2011; Arbour et al., 2023; Naughton et al., 2018). Considering the suggested evolutionary role of disempowerment in experiences of depression (Gilbert, 1992), and the role of empowerment in adults' experiences of recovery (Leamy et al., 2011), it appears that experiences of disempowerment within experiences of depression may not be specific to adolescents. However, it is potentially more common for adolescents, due to their structural position in society and the social reorganisation that takes place at this age.

#### **4.4 Physical embodiment is a marginalised narrative**

The distinction between mind and body, and therefore physical and mental illness, is drawing upon discourses of Cartesian dualism. Since Descartes conceptualised the mind and the body as separate substances (Skirry, 2005), this has come to be understood as common sense, and therefore factual. Conceptualising depression either as a physical or a mental experience are therefore not necessarily factual, but one way of understanding experiences.

Whilst participants primarily drew upon physical discourses, depression is conceptualised as a psychological experience in Western cultures. Medical discourses of depression place physical experiences as a consequence of the mental illness of depression, rather than the experience of depression in itself (APA, 2022). Whilst websites endorsed the medical discourse, participants emphasised the physical conceptualisations of depression, in line with previous findings (Midgley et al., 2015). Adolescents' conceptualisations indicated the heaviness of depression, such as through carrying rocks or boulders,

contrasting with the lightness of recovery. These physical experiences reflect conceptualisations of depression held by non-Western cultures. For example, individuals in China appear to conceptualise depression somatically (Kleinman, 1982). Due to adolescents' physical conceptualisations of depression not aligning with medical discourses, it is likely that they would not be accepted to mental health services by relying on these. This demonstrates how adolescents' conceptualisations are marginalised by dominant discourses, which are based on one way of viewing depression, and may further explain adolescents' reliance on medical language despite their doubts of the model. Other conceptualisations of depression which align more closely with adolescents' ones, suggests that the medical model focusses on narrow experiences of depression. Adolescents could benefit from services which acknowledge wider experiences of depression, and not only those that reflect medical understandings.

The dictionary definition of "depress" is a verb that refers to pressing or forcing down into a lower position by physical action (Oxford University Press, n.d.). This definition therefore not only reflects participants' physical conceptualisations of depression but also the disempowerment adolescents experience throughout their experience of depression. This suggests that participants' conceptualisations are in line with the meaning of the word itself, rather than the dominant psychiatric connotations of the word that have come to be assumed as common sense.

Websites' conceptualisations of depression and recovery reflect a CBT narrative, whereby physical experiences are a maintaining factor of depression, alongside thoughts, feelings and behaviours (Greenberger & Padesky, 1995). However, websites appear to marginalise the physical experiences in favour of the cognitive, behavioural and emotional ones. Therefore, whilst CBT models include the role of physical experiences, it appears that this does not filter into dominant discourses proportionately to the other aspects of CBT. Considering the role of language in how depression is viewed, it is likely that the name of CBT in itself marginalises the physical discourse, only accounting for cognitive and behavioural experiences in its name. CBT is often diagnostically driven and

would therefore account for emotional experiences in this way, as it would be targeted towards the experience of 'depression' or 'anxiety', for example. As CBT is recommended as a first line intervention for adolescents experiencing depression (NICE, 2019), it should be ensured that the physical experiences of depression are emphasised within practice. This could be particularly important considering the development of the prefrontal cortex, and the higher cognitive abilities associated with this area of the brain, that takes place during adolescence (Casey et al., 2008). It is therefore possible that adolescents rely on physical conceptualisations of depression due to the ongoing development of their cognitive abilities. This reflects the use of somatic discourses by Chinese individuals experiencing depression (Kleinman, 1982). Whilst in China, it is often deemed socially unacceptable to express emotions, and physical discourses are therefore relied upon, adolescents are less able to access cognitions and therefore also rely upon physical discourses, suggesting the same function of physical conceptualisations of depression.

#### **4.5 From dismissed child to responsible adult**

Adolescents drew upon the controversy of whether depression 'exists' in adolescence or if these experiences are 'normal' for this age. Adolescents' experiences were dismissed by parents, whether they assumed their experiences were those of depression and were told that they were normal experiences of being a teenager, or vice versa. Either way, adolescents appeared to adopt the narrative that was given to them by others. This could suggest that others, with more social power, provide adolescents with the access to language and explanations that they did not previously have and, consequently, potential actions. It could therefore also suggest that adolescents lack power to have their perspectives acknowledged by others.

Literature suggests that being diagnosed with depression during adolescence increases the risk of being diagnosed with depression as an adult (Rahman et al., 2008). However, the results of this study suggest that gaining responsibility as adolescents transition to adulthood is an important aspect of recovery. This reflects previous literature exploring adolescents' conceptualisations of recovery (Simonds et al., 2014). Further to this, the sense



of increased responsibility into adulthood, and into recovery, could represent a sense of empowerment, also reflective of previous literature (Leamy et al., 2011; Naughton et al., 2018).

#### **4.6 Extended Limitations**

The study only recruited one participant who identified as male and therefore male discourses of depression and recovery are less represented within this research. However, this may reflect the research that indicates adolescent females are twice as likely to be diagnosed with depression than adolescent males in Western cultures (Salk et al., 2017). However, adult males have been reported to conceptualise depression differently to females (Men's Health Forum, 2018), and may therefore not be represented in diagnostic rates due to not meeting the criteria for a diagnosis and being less likely to seek mental health support (Men's Health Forum, 2018). In line with this, it is possible that males may not have identified with the term 'depression' that was used in the recruitment adverts and therefore may not have registered their interest in participating in the study. This could also reflect adolescent males' reduced likelihood to access mental health services; the male who participated in this study had also been accepted for an assessment with CAMHS. Future research could use DA to explore male adolescents' conceptualisations of depression specifically, due to the existing literature demonstrating differences in adult males' conceptualisations. This limitation could extend to all participants, as only individuals who identify with the terms 'depression' and 'recovery' were likely to take part in this research. Dominant discourses may therefore be reinforced by the recruitment advert and study materials, including the title. This could have marginalised the conceptualisations of individuals who do not identify with these terms, and therefore did not take part in the study, even though their experiences may have been relevant to the research questions. There is, however, a pragmatic argument to use widely understood terminology until potentially more appropriate language is developed. Future research could therefore investigate adolescents' preferred terminology for experiences that are dominantly understood to be those of 'depression' or other experiences of mental health problems.

Recruitment took place via social media and mental health charities, and whilst it is not possible to ascertain where each participant was recruited from, there are likely to be implications for the individuals who did take part. For example, the mental health charities posted the recruitment adverts on forums or groups that were for adolescents who had previously registered their interest in taking part in research. Two participants also mentioned in their interviews that they had taken part in research interviews before. It is therefore likely that participants were passionate about the research topic and felt comfortable talking about their conceptualisations within an interview setting. However, some participants who registered interest in taking part in the study contacted the researcher to ask if they could complete the interview in an alternative format, such as over text or email, due to anxiety about taking part in an audio or video interview. This amendment to data collection was granted ethical approval, and therefore increased accessibility of participation to individuals who may not have otherwise taken part in the research study. Further to this, the nature of the experience of depression itself may create barriers to participation in those with more severe experiences related to tiredness or a lack of motivation or interest. Results may therefore be skewed towards the conceptualisations held by individuals with less severe experiences of depression. Further to this, some participants did identify as experiencing depression but reflected that their experiences at the time of the interview were not the most severe that they have had, and some identified that they also identified with being on the path to recovery.

Additionally, the PPI in the development of the study was limited. Whilst relevant experts by experience were approached to be involved, none volunteered to do so. This resulted in a lack of adolescents' perspectives on, and involvement in, different stages of the project, including the interview schedule, appropriate recruitment platforms, data analysis, and report writing. Expert involvement in these different aspects of the project could have empowered young people to further have their voice heard within academic literature and ensured that the study was as meaningful and relevant to them as possible. Research that has involved people with lived experience are more likely to have results that are translated into practice (Ennis & Wykes, 2013).

PPI will therefore be prioritised within the dissemination phase of this project, to increase its impact on both young people and services. Involvement in research can also enable individuals to feel that they are a valuable and valued member of society, as they actively contribute to the issue at hand (Beresford, 2005). However, it could be argued that adolescents' participation in the research itself would have a similar outcome for the adolescents. Participant Laura reflected on her reasons for taking part in the interview: "a lot of young people like myself are rejected from services and what not so it's kinda just like... [taking part in the interview] is what we can do to improve it and make it work". Whilst this does not incorporate all aspects of PPI, it demonstrates that participating in research may help adolescents to actively contribute to matters that are important to them.

#### **4.7 Extended Clinical Implications**

DA research aims to present a challenge to dominant approaches and therefore initiate change (Morgan, 2010). As such, this study has questioned the dominance of the medical model in conceptualising depression and recovery for adolescents. The results of this study suggest that medical discourses of depression and recovery during adolescence should be viewed from a more critical viewpoint, rather than assumed as truth. Attempts should be made to empower adolescents within their relationships, their transition to adulthood, and the narratives that they use to conceptualise their experiences of depression including their sense of embodiment of depression. More flexible criteria for mental health services would help adolescents feel empowered in their experiences of depression and could be a starting point towards changes in structures of mental health services. This could include the acknowledgement of reduced cognitive abilities at this age compared to adults, and the likelihood that adolescents may therefore rely on alternative discourses to conceptualise their experiences.

Clinical psychologists are positioned well within mental health services to challenge common-sense and assumed pathways of care due to their training in a broad range of theory and practice, which includes critical thinking and leadership skills (Health and Care Professions Council, 2023); ability to assess

and consult with wider systems (e.g., Campbell & Huffington, 2008) and utilise system-wide models of change such as trauma-informed care and psychologically informed environments (Homeless Link, 2022; Office for Health Improvement & Disparities, 2022). Clinical psychologists could therefore help empower adolescents to access mental health services and help increase the flexibility of eligibility criteria for this age group. For example, they could ensure that, through adequate staff training, adolescents' voices are being prioritised throughout referral and assessment. Clinical psychologists are also well-positioned to work with service managers in service development to enable teams to continue this emphasis on adolescent voices. However, psychological discourses have been able to grow only within the context of medical ones (Szasz, 2007), and care should be taken to ensure dominant discourses continue to be challenged.

At a higher structural level, however, the findings of this research, and other research exploring adolescents' own experiences could be included within revised clinical guidelines which inform how CAMHS assess and treat depression. This could include a review and development of psychometric tools that are currently used to assess adolescent depression, to ensure relevance to adolescents' experiences and inform service criteria. PPI should be prioritised to inform service development, including development of assessment tools, in line with statutory guidance for the NHS (NHS England, 2017).

Further to this, results indicate the potential to explore non-medicalised approaches, considering adolescents' rejection of the medical model. Clinical psychologists use formulation as an alternative to diagnosis (BPS, 2011), enabling a person-centred approach to an individual's care. For example, formulations should be done collaboratively with a client (BPS, 2011), which could increase their sense of agency in their care (BPS, 2011; Thew & Krohnert, 2015), which has improved recovery for adolescents (Department of Health and Social Care, 2013). Whilst some participants did report a sense of validation from the medical model and diagnostic systems, this should not be assumed for all adolescents, as other participants were dismissive of the medical model. Therefore, formulation could be used as a tool to explore the discourses an

individual draws upon to conceptualise depression and recovery. This could therefore identify if they view a medical approach as validating or dismissing. This could increase the individualised approach to care for adolescents experiencing depression, increasing their feelings of being understood by services, and therefore decreasing their chances of refusing the care offered to them (MacDonald et al., 2021). There is therefore an argument of considering the function and utility of the discourse that is most appropriate for an individual, which could therefore increase their opportunity for recovery. Further to this, formulation could also explore adolescents' individual conceptualisations of recovery to ensure that interventions offered are individualised to their views of recovery.

The results also suggest the potential to explore other non-medicalised approaches that focus on meaning making. As such, approaches including Open Dialogue (Alakare and Seikkula, 2022) or narrative therapy (which takes a social constructionist approach; Freedman & Coombs, 1996), might offer more acceptable approaches to adolescents. However, further research would need to be conducted to determine the feasibility, acceptability and efficacy of such approaches for adolescents experiencing depression.

#### **4.8 Extended Future Research**

Previous research has identified that adolescents' conceptualisations of depression and recovery appear to differ from those held by mental health services (Dundon, 2006; Midgley et al., 2015; Martin & Atkinson, 2018; Del Mol et al., 2019). Whilst this study has explored the discourses drawn upon by websites, this does not necessarily reflect those drawn upon by mental health services. Websites appeared to closely reflect the NICE (2019) guidelines for adolescents experiencing depression. However, services and practitioners are not always aware of the NICE guidelines for their service, and they are therefore not always put into practice (Gyani et al., 2012). It would therefore be beneficial to explore the discourses drawn upon to conceptualise depression and recovery by healthcare professionals working in mental health services. This could compare the discourses drawn upon by CAMHS and adult mental

health services, considering the different structures (Lamb & Murphy, 2013), and within the context of adolescents' transition to adulthood.

Given the marginalisation of adolescents' narratives of the embodiment of depression and recovery, it could be useful for research to explore this in the future. The ongoing development of adolescents' cognitive abilities could warrant further exploration of adolescents' views of CBT. CBT's name and diagnostic focus could be potentially reinforcing the cognitive-behavioural and emotional aspects of the model and marginalising the physical aspects. With physical embodiment discourses of depression being used by adolescents, the dominant connotations of CBT could present a barrier to their engagement with the model. Future research exploring adolescents' perspectives and expectations of CBT could therefore enable services to emphasise the aspects of CBT that are more relevant to adolescents' experiences, given the recommendation of the use of CBT for adolescents experiencing depression (NICE, 2019).

Considering depression and recovery as social constructs, conceptualisations are therefore arguably situated within time and culture. It would therefore be useful for future research to explore how other adolescents conceptualise depression and recovery. For example, the lack of participants under the age of 16 warrants future research into younger adolescents' conceptualisations. Further to this, conceptualisations of depression and recovery are likely to differ within different sociocultural contexts. Exploring the conceptualisations held by adolescents from different cultural backgrounds and a range of socioeconomic status, could be useful, to explore potential nuances in adolescents' conceptualisations of depression and recovery.

Empowering adolescents in the delivery of mental health services begins within research. Any future research following on from the current study should therefore focus on the involvement of relevant experts by experience throughout each stage of the research process. Adolescents experiencing depression should be involved from development of the study through to dissemination, as well as other key stakeholders such as commissioners, education professionals,

and CAMHS service managers. Involving a range of stakeholders would ensure all relevant perspectives are incorporated into the study and that results are as impactful as possible.

## **5. Critical reflection**

### **5.1 Research development**

The motivation behind this research came from my own experiences as an adolescent, then working with adolescents in CAMHS, both as a healthcare assistant in an inpatient unit and then on my placement as a Trainee Clinical Psychologist in a community team. As an adolescent myself, I had never heard of CAMHS and did not really know what mental health was, or who experienced it. I found adolescence a difficult time, struggling with social reorganisation as my friends became more important than my parents, but not understanding why. I experienced fluctuations in my mood which were difficult to control, irritability, a low mood and lack of motivation to do things. Depression, however, was never mentioned in relation to these experiences, nor do I wish it had been. Amongst my peers also, a gratitude for experiencing adolescence before a time of mass social media is consensus, as difficult social relationships always only existed at school. This is why, as I have started progressing through my career, aware of the news, literature, and commissioning that has started to focus on the adolescent mental health crisis, I have reflected on this cultural shift.

As I have started to build and make sense of my professional identity, the aspects of lectures, literature, and clinical work that have resonated with me have related to the way in which narratives can constitute experiences. I have, increasingly over time, become angry about how the medical model of 'mental illness' is assumed in everyday conversations, news, media, and general understandings, and the fact that 'mental illness' is a concept in itself. As I found myself aligning with the social constructionist perspective, I became interested in discourse analysis (see *5.2 methodology*).

Whilst the research had already been conceptualised by this point, my experience on my CAMHS placement was further influential. I noticed how parents' and adolescents' perspectives of the adolescents' difficulties rarely

matched, yet the parent most often held the power. For example, one mum referred her 15-year-old daughter to CAMHS and when they came together for the appointment, the mum listed the symptoms of depression she felt her daughter was experiencing, and the daughter was silent. However, when the daughter got an opportunity to speak to us alone, she described that she was feeling sad because they had moved 200 miles, and she missed her friends and starting a new college knowing no one was difficult. She described that her mum did not understand but she felt unable to talk to her about it because she was so set her experiences being depression. As such, mum's narratives of the daughter's experience marginalised the daughter's perspective, and she had to then justify why she did not want to access CAMHS. I also noted that clinicians became frustrated when adolescents who wanted support did not meet criteria for the service, and alternative third sector services had to be identified, with more flexible, non-medical criteria.

Throughout the process of this research project, I was aware of my motivations, values and emotions that have played a role. I was keen to have involvement from experts by experience throughout my study. However, when various groups were approached, they either had no appropriate group members, or no volunteers came forward. This was a frustrating experience, and I became worried that this reflected a challenging recruitment process ahead. I was also determined, therefore, to remain reflective of how my motivations, emotions and values influenced all aspects of the research, from conception through to data collection, analysis and write-up. It has been difficult, at times, to manage these emotional reactions. I found myself needing to take breaks to regulate my emotional responses and have remained reflective throughout and learnt from mistakes I made.

## **5.2 Methodology**

I was keen to use DA, and it was the best approach to answer the research question. However, I had never previously used DA and, prior to this research, knew very little about it. The field of DA is vast, and I initially struggled to navigate relevant literature. I used previous psychological research (Mellow, 2018; Casey, 2017; O'Key, 2014) to identify relevant literature. My primary



supervisor was also helpful in directing me to influential and relevant books. I found my experience of learning about DA isolative, as no peers also used DA. Throughout my placements, I have spoken to colleagues who have used DA in the past, and it was helpful to hear their perspectives and literature that they favoured.

As with most qualitative research, there is not one definitive way to do DA, which further led me to feel unqualified, without the crutch of following specified steps. However, after weeks of reading about DA, a discussion with my primary supervisor about my feelings of inadequacy helped me to start analysis. Once I had started analysing transcripts and websites and I began to see what the analysis was achieving, the concepts and aims of DA began to solidify for me. I feel, overall, that I have risen to the challenges presented by DA and, although my experience of DA remains very limited, I have enjoyed gaining knowledge of, and using, a new methodology. Should I do any DA research in the future, however, I would be keen to identify any workshops that would explore the use of DA from a psychological perspective.

### **5.3 Data collection**

I remember feeling a high level of anxiety when the first potential participant responded to the recruitment advert, as they declined to give me information that was required for them to be able to participate. I felt worried that this was reflective of how recruitment would proceed. However, recruitment quickly picked up and I had more than enough participants, aged 16 and over, within a few weeks, who were all keen to take part, responsive to emails, and attended arranged interviews. Whilst I felt a sense of relief about this, I was also aware of the lack of participants under the age of 16.

I was mindful that under 16s likely registered their interest without consulting their parents/carers, which seemed to be true. When a potential participant who was under 16 responded to the advert and provided the contact details of their parents/carer, I was anxious about the tone of my initial contact with them. For example, I did not want to assume that they either knew or did not know that their child had registered their interest. Parents/carers did not answer phone calls, and most did not reply to emails. I wanted to ensure that I

followed up emails that were not responded to, within reason, to ensure that the adolescents had the opportunity to take part in something they had registered interest in. However, a few weeks into recruitment I had an email from one parent, stating that they were “*not interested and do not want [child] to take part*”. I felt really angry at the tone of their email, and the barrier that they were putting up to an opportunity for their child to be heard. In my reflective diary, I wrote: “why should that child not get the opportunity to talk about their experiences?? When else does that parent dismiss their child’s wishes and views??” I understood that the child likely had not shared this opportunity with their parent prior to them receiving my email, and the parent may have felt harassed. However, I also reflected on the reasons for why the child had not shared it with their parent, which could have been because they knew what their reaction would have been. I also reflected that parents/carers may not want their children to take part because they did not know, or feel, that their child felt that they were experiencing depression. It was interesting timing to receive this email, because the interview I had done the day before had explored how the participants’ parents’ lack of understanding contributing to their experiences of depression, and I feel this likely fuelled my reaction to the email.

I did note, however, that my emotional reaction to this email, and therefore the wider barrier for adolescents’ participation in research, was mostly one-sided towards negative perceptions of parents. I therefore tried to put myself in the parents’ shoes and think what I would experience if I had received that email about my child. I wrote in my reflective diary: “internet is dangerous? Wouldn’t want my child to speak to a stranger online? Would I try and find out more about the researcher though, and their qualifications? Wouldn’t even do that now though – too busy! Parents probably even busier.” It helped to view the situation from the parents’ perspective, to reduce the intensity of my emotional reaction, but I still felt a sense of injustice for the adolescent, and all of those who were unable to take part due to parental barriers.

Overall, the data from adolescents’ interviews were generally over and above my expectations. Firstly, I did not expect to have as many participants as I got, and secondly, I did not expect them to talk so openly about their

experiences of depression. However, I was expecting topics such as war, climate change, and social media, to be discussed. Only one participant mentioned world events in passing and did not elaborate. Two participants mentioned the role of social media although one of these was the first interview, and I had felt a pull at the end of the interview to bring up social media because she had not mentioned it. I reflected on this after the interview, and the significance of the fact that she had not brought up the role of social media herself. I realised that in introducing a discourse into the interview, I was potentially marginalising her own experiences by assuming my own perspectives as correct. I therefore ensured that in following interviews I did not introduce discourses or concepts that I felt they had 'missed', to ensure that they did not adopt my perspectives.

With different methods of participant interviews, including video call, audio call, and chat, interviews, and therefore data, differed in their quality. I found chat interviews the most difficult, as tone, emphasis and other discursive effects, are difficult, if not impossible, to rely upon. For example, I was unable to tell if someone was thinking about their answer to my question, spending a long time typing, or were not planning on replying to that question at all. I found myself getting most frustrated with participants in chat interviews, compared to other types. It felt that this was a result of not having access to the discursive effects of the talk. Interestingly, I also felt the same when reading the interview data. This demonstrated to me the amount of information that we get from language that is spoken rather than written, and how this might impact on adolescents' worlds if they exist online more than ever.

#### **5.4 Analysis**

I initially found analysis challenging, with the combined DA approaches and the fact that DA was new to me. However, as already mentioned, once I started analysis it began to make more sense to me and became easier. I found the difference in analysing written text (websites and chat interviews) and spoken text (transcribed audio or video interviews) an interesting comparison. Whilst analysing transcribed interviews, I could remember the different intonations in people's talk, which was reflected in the transcription conventions. This helped

to contextualise participants' speech and helped with aspects of the analysis such as action orientation and subject positions, for example in instances where sarcasm was used. I found the written text, particularly the websites, less interesting to analyse, although this could have reflected my preoccupation with prioritising adolescents' experiences. I felt that I would not find anything interesting, or that I was not expecting, in the websites. However, once websites were analysed and I began the write up, I began to find the comparisons between websites' and participants' use of discourses really interesting and was glad that the websites were being analysed as well as participant interviews. I began to feel that the website data was an important aspect of the research, to contextualise adolescents' conceptualisations. Before this, throughout the research process, I felt that I was viewing the websites somewhat as an add-on rather than an integral part of the research. I was glad that analysis changed my perspective of this, and I felt that this was reflected in the write-up.

Whilst some interviews stood out to me more than others, the process of analysis changed my perspective of Fraser's interview the most. During the interview, Fraser was walking his dog in the park. We had a conversation at the beginning about the nature of the interview and whether Fraser was happy with this environment, which he was. I found the interview frustrating, as whenever Fraser noticed others nearby, he would stop talking to try and move somewhere more private or wait for others to pass by. This was understandable, and I encouraged him being in a private place away from others, but it meant that the interview was disrupted. I felt that I had a good rapport with Fraser, but the disruption made me wonder at the time if it was going to be a wasted interview, without any usable data. However, I realised that this perception of the interview was completely wrong, when I began to transcribe and analyse it. My initial reflection when analysing, was that the reason Fraser chose to do his interview in the park was because he did not want to do it at home for his parents to overhear. This was also important to consider as Fraser was the only participant under the age of 16, and therefore the only participant whose parent had to consent to his participation. Whilst, as an adolescent, it is understandable that Fraser wants to have experiences that are private from his parents, it also indicates that he does not feel understood by them. The overwhelming sense

from his interview was his experience of bullying, dismissal from others, and fear of discrimination, which all played a role in his experience of depression. This contextualised his interview in the park and reflected his experiences of isolation. Therefore, my frustration at the disjointed nature of the interview subsided, and more empathic feelings began to arise in relation to Fraser, as I analysed his interview and began to see his experiences from his perspective.

## **5.6 Terminology**

I have referred to the experiences of adolescents as depression throughout this project, including in the title, recruitment adverts and interviews. It is challenging to navigate the use of terminology such as 'depression', considering its conceptualisation as a 'mental disorder'. Using the term 'depression' also suggests that it exists as a real entity and endorses medical conceptualisations. Whilst, ideally, this term would not have been used in this research, it would create practical problems, such as with recruiting appropriate participants. I find it frustrating using medical terminology relating to diagnostic criteria, including 'depression', as I know this endorses the medical model. However, realistically, the term 'depression' is commonly understood in Western cultures to capture a certain experience. It was therefore felt that this was the most appropriate terminology to use, and attempts have therefore been made throughout the report to reflect the social constructionist perspective, such as 'felt that they were experiencing depression', or 'experiences that were considered to be of depression'. I felt that this was a compromise between my epistemological position and practicalities of research. I noticed that this reflected my perspectives in clinical work, during discussions when clients' difficulties are described using a diagnostic category, rather than what they are experiencing at that time that is distressing for them.

I have similar feelings to the term 'recovery', with its medical connotations. My personal, and professional stance would be similar to a social constructionist one: how can someone recover from something that does not exist? I therefore felt that, similarly to 'depression', using 'recovery' as terminology throughout the research materials, interviews, and report, was a compromise. It is likely that, in the Western world, there is consensus on what

was meant by 'recovery', and this enabled identification of appropriate participants. Further to this, when talking about recovery in interviews, I always introduced the concept of recovery but asked how they might refer to it in their own language. This was helpful to ensure that participants' language was drawn upon, and they did not feel that 'recovery' was the assumed language. This left it open for some participants to refer to their experiences as recovery, whilst others used alternative language such as 'getting better'.

### **5.7 Researcher positioning**

It is important to consider how I was positioned within the research, particularly with interviews. I felt conscious of the power imbalance inherent in the relationship between myself and participants. I was conscious that my position as a researcher might place me in an 'expert' role within the interviews. I tried to reduce this power imbalance where possible, ensuring that participants were aware of my interest in their experiences and perspectives, and that I was not looking for any 'right' or 'wrong' answers. I, rightfully, emphasised that I did not know anything about their experiences. This was interesting to reflect on, with perhaps a handful of participants positioning themselves, towards the end of their interviews, as experts who were advising me:

Emma: its sort of something that becomes normal to you when you go through it, you want to recover but its so much of a task that it feels like you might as well be climbing mount everest and its a mental barrier that can be exhausting to get over, you really dont think you can do it it might be like building yourself up to go on some scary rollercoaster, long-term itll be good and fun and you'll be glad you did it but going through it is some emotion joyride you dont know what to expect and that normalcy is also comforting for some people

even if it can be miserable and hold you back from a lot of things  
Interviewer: so even though it can feel like too much to deal with, it's worth it in the long term?

Emma: yeah definitely its one of those things you have to do if you want to get better, people dont like going out of their comfort zone but its absolutely necessary for things to change

I felt that this was a positive reflection of how I managed the power imbalance, and it felt that participants had been empowered in exploring their experiences and conceptualisations with me.

It was also important to consider my role in the interviews, as qualitative and social constructionist perspectives view researchers as active and influential in research interviews (Silverman, 2015). This contrasts with research taking a positivist stance, where experiments are tightly controlled to ensure that the researcher does not influence results (such as double blinding in placebo trials). Whilst my recent research experience has been qualitative, and this was therefore not a new reflection for me, the DA perspective was a novel one. I was careful to consider the language I used in interviews, to keep language open and not introduce discourses that participants had not already drawn upon. Reading literature about narrative therapy techniques such as deconstructive listening and questioning (Freedman & Combs, 1996) was helpful in the approach I took to interviews. For instance, this helped me be careful to ask questions such as “when you say ‘x’, what do you mean?” rather than “what does that look like for you?”. I noticed, during analysis, that I did occasionally use language that was less open, but I often noticed at the time and tried to reframe my question, such as in my interview with Ceara: “just kind of talking about kind of getting better and u:m ... what would that look like—what would that be like?”. This approach in interviews has also made me view my clinical work differently, and I notice that I am much more careful with the language I use with my clients, and with colleagues.

I also tried to remain reflective of my values and perspectives throughout the research. I felt that writing my extended introduction fuelled my anger at the fact that medical model, and the DSM, has just been assumed as fact. I therefore tried to notice when my feelings were influencing my writing, or analysis, and ensured to take breaks. I often went for walks, listened to calming music or an easy-read audiobook, until I felt that I could view the analysis or writing more objectively. Essentially, it is impossible to remove my subjective views from the project, but I have attempted at least stay reflective and aware of them. I tried to ensure that my perspectives about the medical model did not

influence the interviews with participants as well. I tried to stay objective and interested in their experiences if medical connotations were raised, rather than assuming that they were rejecting of the medical model.

Lastly, despite my subjective viewpoints of the medical model, and my alignment with a social constructionist perspective, I found it difficult during the write up to distance myself from the positivist literature. I found that throughout the literature, depression is often framed as a fact, and my supervisor noticed that this was reflected within my writing despite my epistemological stance. As I worked on this feedback, I reflected how it took additional time, energy and thought to reframe the literature in a social constructionist way; the positivist perspective is already written. I reflected that this also present within the role of clinical psychologists within mental health services, challenging unhelpful conceptualisations of mental health problems. I have noticed in my own clinical work, it sometimes feels easier to let the medical model dominate, and it can be challenging to always question the status quo. I also thought about how this reflected the clinical psychologist proficiency of being a scientist-practitioner (Health and Care Professions Council, 2023). There is often the need to balance psychological perspectives of individuals' difficult experiences with a traditional positivist scientific approach, both within clinical and research work. I have therefore reflected how, in my clinical work, whilst I can align with a social constructionist perspective, I need to hold this in mind flexibly. For instance, where clients find the medical model validating, I acknowledge this within their formulations, and will aim to identify where holding alternative positions may be better practice.



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## Appendices

### Appendix A: Ethical Approval



**DPAP Committee: 19/04/2023**

**Supervisor: Dr Anna Tickle**

**Applicant: Miss Megan Dixon**

**Project ID: 2992**

**Project Title: Adolescents' Views of Depression and Recovery: A Discourse Analysis**

Dear Megan

The committee is pleased to confirm that the above study now has approval on the basis of your application and any subsequent clarifications. You must conduct your research as described in your application, adhere to all conditions under which the ethical approval is granted, and use only materials and documentation specified in your application.

If you need to make any changes (for example to extend your data collection timeframe, change the mode of data collection, or the measures being used), you must create and submit an Amendment Form. To do this, select the 'Create Sub Form' option from the Actions Menu on the left-hand side of the page in the online system and then select 'Amendment Form'.

With best wishes

A handwritten signature in black ink, appearing to read 'Jen Yates'.

Dr Jen Yates

Chair of the DPAP Ethics Subcommittee

## Appendix B: Ethical Approval: Amendment



**DPAP Committee: 05/07/2023**

**Supervisor: Dr Anna Tickle**

**Applicant: Miss Megan Dixon**

**Project ID: 2992**

**Project Title: Adolescents' Views of Depression and Recovery: A Discourse Analysis**

Dear Megan

The committee is pleased to confirm that the amendment relating to review reference DPAP - 2023 - 2992 – 2 has received approval. Please conduct your study following the amended procedures. If you need to make any further changes, please create a new amendment form.

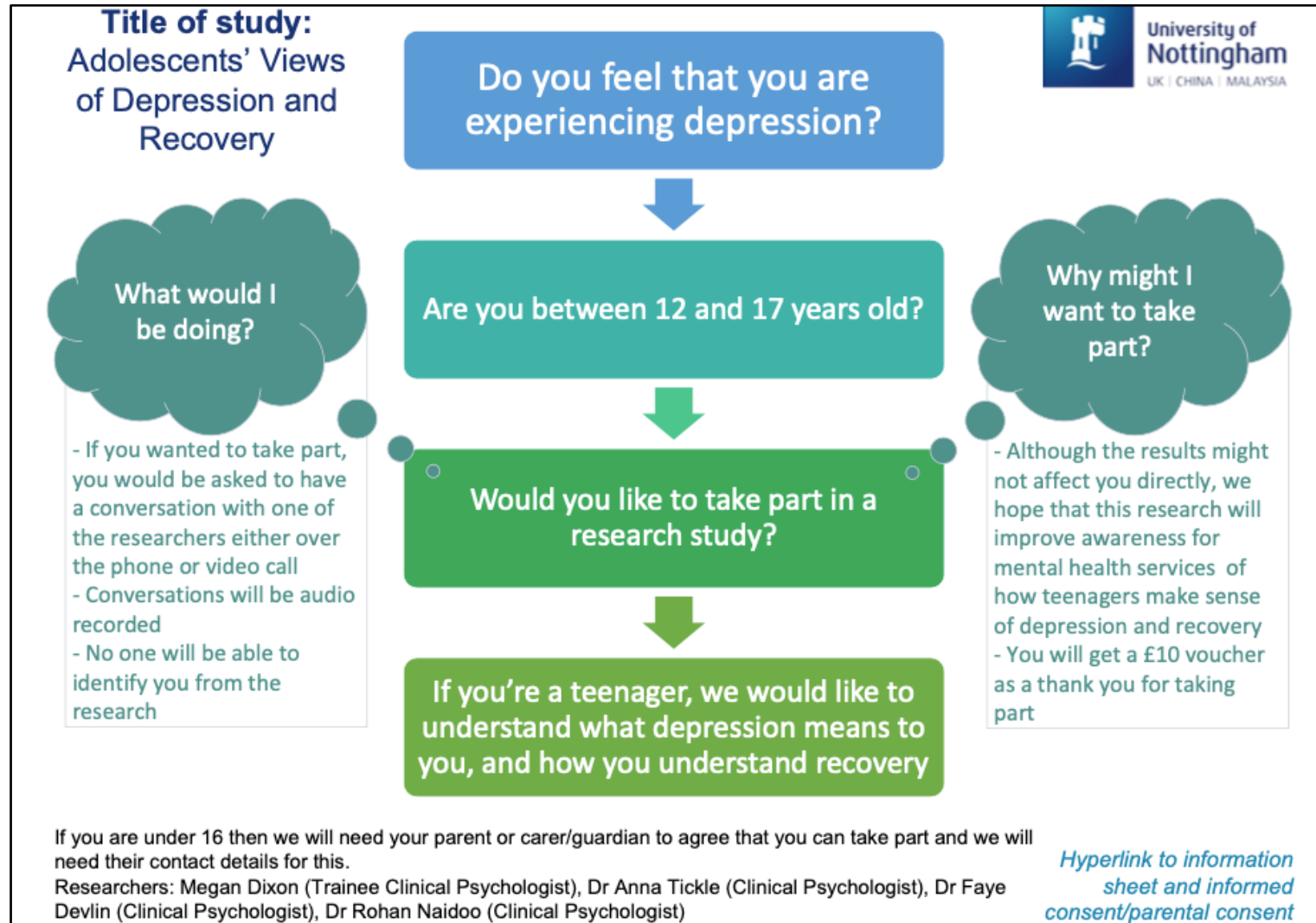
yours sincerely

A handwritten signature in black ink, appearing to read "Jen Yates".

Dr Jen Yates

Chair of the DPAP Ethics Subcommittee

## Appendix C: Recruitment Advert



## Appendix D: Charity Recruitment Advert

### WOULD YOU LIKE TO TAKE PART IN RESEARCH?

A research team at the University of Nottingham are interested in understanding a bit more about what depression means to teenagers, and also what you feel that recovery is like. We hope that this will improve awareness for mental health services, so that they can understand how teenagers make sense of depression and recovery. We would love to chat to some [REDACTED] users to find out more and help us do this.

If you would like to take part, you would be asked to have a conversation with one of our researchers which could take around an hour. This will be either by video call (over Microsoft Teams) or over the phone, depending on what you would prefer. These conversations will be audio recorded so that we can look back at exactly what everyone has said.

If you choose to take part, you will not be anonymous to the researchers as we will be talking to you directly. You will still be anonymous to [REDACTED] though, and we won't tell them anything that you say in our interview. No one else outside of the Nottingham Research team will be able to identify you from the research either.

You can take part if:

- You feel that you are currently experiencing depression
- You are between 12 and 17 years old

If you are under 16 then we will need your parent or carer/guardian to agree that you can choose to take part and we will need their contact details for this. They will not need to know that you are using [REDACTED] though.

If you would like to take part in this research, please follow this link: <https://forms.office.com/e/qdAi51RDck> to fill in your details so that the researchers can contact you.

You will also be given a £10 gift voucher as a thank you for taking part!

Megan Dixon (Trainee Clinical Psychologist)  
Dr Anna Tickle (Clinical Psychologist)  
Dr Faye Devlin (Clinical Psychologist)  
Dr Rohan Naidoo (Clinical Psychologist)

## Appendix E: Under 16's Participant Information Sheet



### Under 16's Participant Information

STUDENT RESEARCH PROJECT ETHICS REVIEW.

Division of Psychiatry & Applied Psychology

(Draft version 2.0: 30.03.2023)

Project Title: Adolescents' Views of Depression and Recovery

Student: Megan Dixon [megan.dixon@nottingham.ac.uk](mailto:megan.dixon@nottingham.ac.uk)

Supervisor: Anna Tickle – Primary Research Supervisor [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk)

Faye Devlin – Secondary Research Supervisor [fdevlin@lincoln.ac.uk](mailto:fdevlin@lincoln.ac.uk)

Rohan Naidoo – Secondary Research Supervisor [mszrjn@exmail.nottingham.ac.uk](mailto:mszrjn@exmail.nottingham.ac.uk)

We would like to invite you to take part in a research study about what depression means to young people. Before you begin, we would like you to understand why the research is being done and what we'd like you to do.

Why are you asking me?

We would like to talk to teenagers (aged 12-17) who have low mood, or depression.

Please read the information below to see if you would like to take part.

We recommend that you discuss this information with an adult that you trust before you decide whether you would like to take part or not. If you have been sent this information sheet then it means that a parent or carer has already told us that they are happy for you to take part.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.





### What is this research for?

- We want to understand what depression means to teenagers, and how they understand recovery too. This study is part of a piece of work for University

### What will I have to do?

- If you want to take part, you'll be asked to have a chat with a researcher about what depression and recovery mean to you. We might ask questions such as what your experience of depression is like and what recovery would be like for you. We might also ask about your age and gender
- This could take about 1 hour. We can take a break if needed, and we can also have two separate sessions if you would prefer. Our conversation will be over the phone or Microsoft Teams, and it will be audio recorded

### Do I have to take part?

- No! It is up to you.
- If you want to take part, we'll ask you to sign a form saying you agree to take part
- We will need permission from your parent or carer for you to take part as well - they will also need to sign a form

### What if I change my mind?

- You can change your mind about taking part at any point. We will also stop the conversation at any point if you let us know you don't want to carry on
- If there's any questions that you don't want to answer that's okay as well - just let us know!
- If, after our conversation, you realise you don't want us to include your conversation in our research, you can let us know up to one week afterwards - just contact the researcher
- We won't be able to delete your information after this as it may have already been used in the research

### Will this help me?

- It might not directly help you, but some people find it helpful to talk about their experiences
- We hope that the information we get from this study will improve awareness that mental health services have of teenagers' experiences of depression, which could help the support they give teenagers in the future
- You will be given a £10 voucher as a thank you for taking part

### Will this harm me?

- We don't expect this to harm you - but we will be talking about your experience of depression, which could be upsetting. We can stop or pause the conversation whenever you want
- We'll make sure there's time at the end to talk about how you're feeling and any more support you might need



### Where can I get support?

- If you are affected by any of the issues raised by taking part in this study, we recommend that you talk to the supportive people around you such as any friends or family. If you feel that you need to talk to someone else, here are some different options for services that may be able to provide help and advice:
  - Your GP
  - Shout: 24/7 free text service, 85258
  - The Mix: 0808 808 4994 or online chat (both 4pm-11pm, <https://www.themix.org.uk/>)
  - Samaritans: 116 123 or email [jo@samaritans.org](mailto:jo@samaritans.org)
  - Childline: 0800 1111 free phonenumber, or free counsellor chat online <https://www.childline.org.uk/get-support/1-2-1-counsellor-chat/>

## Appendix F: 16+ Participant Information Sheet



University of  
Nottingham  
UK | CHINA | MALAYSIA

### 16+ PARTICIPANT INFORMATION

#### STUDENT RESEARCH PROJECT ETHICS REVIEW

Division of Psychiatry & Applied Psychology  
(Draft version 4.0: 30.03.2023)

Project Title: Adolescents' Views of Depression and Recovery

Student: Megan Dixon [megan.dixon@nottingham.ac.uk](mailto:megan.dixon@nottingham.ac.uk)

Supervisor: Anna Tickle – Primary Research Supervisor [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk)

Faye Devlin – Secondary Research Supervisor [fdevlin@lincoln.ac.uk](mailto:fdevlin@lincoln.ac.uk)

Rohan Naidoo – Secondary Research Supervisor [mszrjn@exmail.nottingham.ac.uk](mailto:mszrjn@exmail.nottingham.ac.uk)

Ethics Reference Number: 2992

We would like to invite you to take part in a research study about what depression means to young people. Before you begin, we would like you to understand why the research is being done and what it involves for you.

#### What is the purpose of this study?

This study aims to understand what depression means to teenagers, and how they understand recovery too. This study is being carried out for educational purposes by a student on the Doctorate in Clinical Psychology programme and the findings will be written up as part of a thesis.

#### Why have I been invited?

You have been invited because you have replied to an advert you have seen online. We would like to talk to teenagers, aged 12-17, who are currently experiencing low mood or depression. We would like about 10 people to take part.

#### Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, we will ask you to provide consent in an online form. We recommend that you discuss taking part in this study with an adult that you trust.

You may change your mind about being involved at any time or not want to discuss a particular question. Taking part is voluntary and you can stop at any time, without giving me a reason. If you want to stop the interview, just tell us and we will stop collecting any information about you or from you. You can ask us to remove your information from the study up to a week after you have spoken to the researcher – you do not need to give us a reason. You can contact the researcher who can delete your information. If you change your mind after 1 week, we won't be able to delete your information as it may have already been used.

#### What will I be asked to do?

If you choose to take part, you will be asked to have a conversation with a researcher about what depression and recovery mean to you. This could include questions such as what your experience of depression feels like, how it impacts your life, and what recovery would be like for you. You may also be asked questions such as your age and gender. The conversation could take approximately 1 hour. We can take a break during the conversation if needed, and we can



also have two separate sessions if preferred. This will take place over the phone or online via Microsoft Teams. This conversation will be audio recorded.

**Will the research help me?**

There is no direct benefit to you from taking part, although some people find it helpful to talk about their experiences. We hope that the information from this research can improve awareness that mental health services have of how teenagers understand depression. We hope that this will mean services are able to help teenagers more in the future.

In recognition of your participation, you will be given a £10 voucher.

**What are the reasons to not take part?**

We don't expect there to be any disadvantages or risks to taking part. However, as we are talking about your experiences of depression, you might get upset. We can stop the interview whenever you need and will make sure there is time at the end to talk about how you are feeling and any more support you might need.

**What will happen to the information I provide?**

After the interview, the recording will be typed up word for word either by the researcher or an automated service provided by the University of Nottingham. I'll change your name and other details so that no one will know it's you. These documents will be password protected and deleted once the study is complete. Only the research team will have access to the audio recordings and transcribed interview data. I will put together your interview with the others, to look closely at the language you all use. I will write a report which will be part of my university assignment and the findings might be shared with mental health services. The findings might also be sent to a journal which is read by experts. We would like to be able to quote what you say in reports or [publications](#) but we will make sure it is not possible to tell that it is your quote, but if you do not wish us to quote you, please tell us. Everything will be anonymous so people will not be able to identify you or know that you have taken part.

If you tell us something that suggests you or other people are at risk of harm (either from yourself or other people), we will have to tell appropriate services to help keep you safe. In this instance, your identity will not be protected anymore

The information that you provide will be used to write a thesis for the partial fulfilment of the *Doctorate in Clinical Psychology* and may also be used to write academic papers to be published in peer-reviewed journals and in presentations at conferences. If you would like a summary of the results, please email the supervisor [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk) for a copy.

We will follow ethical and legal practice and all information will be handled in confidence. Under UK Data Protection laws, the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum [personally-identifiable](#) information possible. You can find out more about how we use your information and to read our privacy notice at: <https://www.nottingham.ac.uk/utilities/privacy.aspx>

We would like your permission to use anonymised data in future studies, and to share our research data (e.g., in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and



therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

#### **What if there is a problem?**

If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee [rita.gohil@nottingham.ac.uk](mailto:rita.gohil@nottingham.ac.uk) who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: [FMHS-ResearchEthics@nottingham.ac.uk](mailto:FMHS-ResearchEthics@nottingham.ac.uk)

#### **Sources of support**

If you have been affected by any of the issues raised by taking part in this study, we recommend that you talk to the supportive people around you such as any friends or family. If you feel that you need to talk to someone else, here are some different options for services that may be able to provide help and advice:

- Your GP
- Shout: 24/7 free text service, 85258
- The Mix: 0808 808 4994 or online chat (both 4pm-11pm, <https://www.themix.org.uk/>)
- Samaritans: 116 123 or email [jo@samaritans.org](mailto:jo@samaritans.org)
- Childline: 0800 1111 free phonenumber, or free counsellor chat online <https://www.childline.org.uk/get-support/1-2-1-counsellor-chat/>

## Appendix G: 16+ Participant Consent Form

### Informed Consent form for participants 16+



Consent form  
(Draft version 6.0: 30.03.2023)

Title of study: Adolescents' Views of Depression and Recovery

Primary Researcher: Megan Dixon, [megan.dixon@nottingham.ac.uk](mailto:megan.dixon@nottingham.ac.uk)

Supervisors: Anna Tickle: [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk)

Faye Devlin: [fdevlin@lincoln.ac.uk](mailto:fdevlin@lincoln.ac.uk)

Rohan Naidoo: [mszrjn@exmail.nottingham.ac.uk](mailto:mszrjn@exmail.nottingham.ac.uk)

Name of Participant:

Please tick box

1. I confirm that I am 16 or older
2. I confirm that I have read and understand the information sheet version number 5.0 dated 02.03.2023 for the above study and have had the opportunity to ask questions.
3. I understand that my participation is voluntary and that I am free to withdraw within 1 week of the interview, without giving any reason, and without my care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.
4. I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research team and regulatory authorities where it is relevant to the study. I give permission for these individuals to collect, store, analyse and publish information obtained from my participation in this study.
5. I agree for my data to be shared with other researchers in the future, as long as I am not identifiable from the data.
6. I understand that my personal details will be kept confidential.
7. I understand that my conversation with the researcher will be kept private unless the researcher is worried about my safety or the safety of someone else, or they are discussing the research with the other researchers involved with this project as detailed above. If the researcher is worried, they will tell the appropriate people and will try to inform me about this, where possible.
8. I agree to take part in this study.
9. I would like my contact details to be kept on file so that I can be emailed a copy of the research findings.

10. I agree to provide contact details of a parent/carer and my location only for use in case of an emergency during interview.

\_\_\_\_\_                      \_\_\_\_\_                      Tick box for confirmation of  
Name of participant                      Date                      consent

Contact details for researcher to contact me on to arrange interview and send findings:

Telephone \_\_\_\_\_                      Email address \_\_\_\_\_

Contact details of a trusted adult in case of an emergency during interview (these will not be used unless there is an emergency during interview and will be destroyed after you take part):

\_\_\_\_\_                      \_\_\_\_\_  
Name of trusted adult                      Contact number

## Appendix H: Participant Debrief

### Participant debrief



#### Participant debrief sheet

(Draft version 3.0: 30.03.2023)

Title of study: Adolescents' Views of Depression and Recovery

Name of researcher: Megan Dixon (megan.dixon@nottingham.ac.uk)

We would like to thank you for taking part in our research study. This research will provide really helpful information and will hopefully broaden our understanding of how teenagers understand depression and recovery. Please let the researcher know any concerns that this conversation has brought up for you.

#### **Questions and withdrawing**

If you have any further questions about the study, please feel free to ask the researcher before you finish or alternatively contact the researcher or their supervisor at any time on the email addresses above. If you wish to withdraw your data please also contact the researcher or supervisor on these email addresses. Please note you will only be able to withdraw up until the point of data analysis.

#### **Further help and support**

If you have any ethical concerns regarding the current research, your treatment as a participant or your involvement in the study please feel free to contact the supervisors on their email addresses above.

If you have been affected by any of the issues raised by taking part in this study, we recommend that you talk to the supportive people around you such as any friends or family. If you feel that you need to talk to someone else, here are some different options for services that may be able to provide help and advice:

- Your GP
- Shout: 24/7 free text service, 85258
- The Mix: 0808 808 4994 or online chat (both 4pm-11pm, <https://www.themix.org.uk/>)
- Samaritans: 116 123 or email [jo@samaritans.org](mailto:jo@samaritans.org)
- Childline: 0800 1111 free phoneline, or free counsellor chat online <https://www.childline.org.uk/get-support/1-2-1-counsellor-chat/>



## Appendix I: Parent/Carer Information Sheet

### Parent/Carer Information Sheet



Parent/carers information sheet  
(Draft version 4.0: 02.03.2023)

Title of study: Adolescents' Views of Depression and Recovery: A Discourse Analysis

Primary Researcher: Megan Dixon, [megan.dixon@nottingham.ac.uk](mailto:megan.dixon@nottingham.ac.uk)

Supervisors: Anna Tickle: [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk)

Faye Devlin: [fdevlin@lincoln.ac.uk](mailto:fdevlin@lincoln.ac.uk)

Rohan Naidoo: [mszrjn@exmail.nottingham.ac.uk](mailto:mszrjn@exmail.nottingham.ac.uk)

### Introduction

I am a trainee clinical psychologist based at the University of Nottingham completing a professional doctorate in clinical psychology. I would like to invite your child to take part in my research study. They have seen this study advertised and have provided your contact details so that I can gain your consent for them to take part. Before you decide if you would like your child to take part, I would like you to understand why the research is being done and what it would involve for the young person who would like to take part. Please take your time to read the following information carefully and talk to others about it if you wish. Please let me know if you have any questions.

### What is the study about?

The purpose of this research is to understand what depression means to teenagers, and how they understand recovery too. This study is also being undertaken as a thesis for part of a doctorate in clinical psychology.

### Why am I being involved?

I would like to interview young people who are experiencing low mood or depression. The young person must be aged 12-17 and you must be the primary care giver for the young person to provide consent. You are being asked to consent to their participation because they are under 16.

### Does my child have to take part?

It is up to you to decide whether you would like them to take part or not. If you decide that they can take part, they can change their mind and stop being involved at any point before or during the interview without giving a reason. This would not affect their legal rights.

If you do not give your permission for your child to take part, neither of you will have any further contact with us.

### **What will happen to them if they take part?**

If you decide after reading this information that you are happy for your child to take part in this research, I will ask you to complete and sign a consent form. The young person will be asked to provide assent, which is an agreement to take part. After consent has been obtained, an interview appointment will be booked with the young person.

The interview with a researcher will be about what depression means to them, and how they understand recovery. The researcher may also ask them some other questions, such as their age and gender, and where they might think about going to for help with their mental health.

The conversation could take approximately 1 hour. We can take a break during the conversation if needed, and we can also have two separate sessions if preferred. This conversation can take place on a video call or telephone call depending on their preference. If they are interested in taking part but cannot access a telephone or computer, we will make every effort to arrange a way for them to take part.

This conversation will be audio recorded by the researcher (no video will be recorded if they would like a video call). The recording will be kept private on a secure device and will then be written up in a document that is password protected, and there will not be any information in this document that will identify them (i.e., names and places that they mention). Once this has been completed, the recording will be permanently deleted.

### **Expenses and payments**

In recognition of their participation, your child will be given a £10 voucher.

### **What are the possible disadvantages and risks of taking part?**

We expect any disadvantages of taking part to be minimal. During the interview your child will be talking about mental health and depression and how they feel they could get better, and there is a chance that these conversations could be upsetting for them. However, as they can stop the interview at any point, we can do this if they are finding the conversation too difficult. I will ensure we have a space at the end of the interview to de-brief. We can also provide details of services that they can contact for support if they feel [hey](#) need it and would also recommend that they speak to people around them who are supportive.

### **What are the possible benefits of taking part?**

There may not be any direct benefits for your child, although some people find it helpful talking about their experiences. It is hoped that the information we get from this study may improve the awareness that mental health professionals and services have of how adolescents understand depression. This could benefit teenagers in the future when they are trying to get help for their depression.

### **Will their taking part in the study be kept confidential?**

We will follow ethical and legal practice and all information about your child will be handled in confidence.

If your child joins the study, we will use information collected from them during the course of the research. This information will be kept **strictly confidential**, stored on a password protected database at the University of Nottingham. Under UK data protection laws the university is the data controller (legally responsible for the data security) and the chief investigator of this study (named above) is the data custodian (manages access to the data). This means we are responsible for looking after their information and using it properly. Their rights to access, change or move their information are limited as we need to manage their information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard their rights we will use the minimum personally-identifiable information possible.

You can find out more about how we use their information and to read our privacy notice at:

<https://www.nottingham.ac.uk/utilities/privacy.aspx>.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to your child as a research participant and we will do our best to meet this duty.

Your child's contact information will be kept by the University of Nottingham for 6 months after the end of the study so that we are able to contact them about the findings of the study (unless they advise us that they do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. After this time their data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain their confidentiality, only members of the research team given permission by the data custodian will have access to their personal data.

In accordance with the University of Nottingham's, the government's and our funders' policies we may share our research data with researchers in other universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that they could not be identified) but if we need to share identifiable information we will seek their consent for this and ensure it is secure.

Although what they say to us is confidential, should they disclose anything to us which we feel puts them or anyone else at any risk of harm, we may feel it necessary to report this to the appropriate persons.

### **What will happen if they do not want to carry on with the study?**

Taking part is voluntary and they are free to stop at any time, without giving any reason, and without their legal rights being affected. If they decide at any point that

they do not want to continue the interview, then it will be stopped, and we will no longer collect any information from them. If they wish to withdraw their data from the study after they have completed their interview, they have up to one week to let us know. After one week however, we may not be able to remove their information from the results as it may have already been transcribed. If they withdraw after this time period, we will keep the information about your child that we have already obtained as we are not allowed to tamper with study records, and this information may have already been used in analyses. To protect yours and your child's rights, we will use the minimum personally-identifiable information possible.

### **What will happen to the results of the research study?**

The transcripts from your child's interview will be anonymised, collated with other participants' responses, and analysed to produce a set of findings. These anonymised transcripts may also be looked at by other researchers at the University of Nottingham and University of Lincoln. The findings will be summarised and reported in my thesis for my doctorate in clinical psychology. A copy of this thesis will be available at the University of Nottingham library. The results may also be published in journals and may be shared at conferences. Your child will not be identifiable in any publication, and if you or your child wish to have a copy of the results then this can be arranged.

The results of the study will be shared with the services that participants are recruited from. This will be a short summary and will also be anonymous.

If you would like a summary of the results, please email the supervisor [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk) for a copy.

### **Who is organising and funding the research?**

This research is being organised and funded by the University of Nottingham.

### **Who has reviewed the study?**

All research in healthcare is looked at by independent group of people, called a research ethics committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham's Research Ethics Committee.

### **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the start of this information sheet. If you remain unhappy you can contact the Division of Psychiatry and Applied Psychology Research Ethics Committee ([MS-DRAPEthics@exmail.nottingham.ac.uk](mailto:MS-DRAPEthics@exmail.nottingham.ac.uk)).

Although it is unlikely, in the event that something does go wrong, and your child is harmed during the research, and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs.

## Appendix J: Parental Contact Details Form

### Parental Contact Details Form



#### Parental Contact Details Form (Draft version 3.0: 30.03.2023)

Title of study: Adolescents' Views of Depression and Recovery: A Discourse Analysis

Primary Researcher: Megan Dixon, [megan.dixon@nottingham.ac.uk](mailto:megan.dixon@nottingham.ac.uk)

Supervisors: Anna Tickle: [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk)

Faye Devlin: [fdevlin@lincoln.ac.uk](mailto:fdevlin@lincoln.ac.uk)

Rohan Naidoo: [mszrjn@exmail.nottingham.ac.uk](mailto:mszrjn@exmail.nottingham.ac.uk)

Thank you for reading our advert and clicking the link to take part. The purpose of this form is so that we can contact your parent or carer to check that they are okay for you to take part in the study. The researcher will use the details you provide to send further information about the study for both you and your parent/carer to look at.

Name of participant:

Name of parent/carer:

Phone number of parent/carer:

Best time for contacting parent/carer by phone:

Morning

Afternoon

Evening

Email address of parent/carer:

## Appendix K: Example initial email to Parents/Carers

### Example Email to Parents/Carers



#### Subject of email

Research opportunity: Adolescents' Views of Depression and Recovery

#### Email

Dear [insert name of parent/carer as detailed on contact details form],

My name is Megan Dixon and I am a Trainee Clinical Psychologist at the University of Nottingham. I am emailing you as [insert potential participants' name] has expressed an interest in taking part in my research study looking at how adolescents understand depression and recovery. As [insert potential participants' name] is under 16, they have been asked to provide your contact details as you have parental responsibility for them, and we therefore require your consent for them to take part in the study.

Please find attached some further information for you about the research study. Below is a link to a consent form for you to fill in should you agree for [insert potential participants' name] to take part. It is completely up to you if you would like [insert potential participants' name] to take part or not. If you consent to their participation, we will also be seeking further consent from [insert potential participants' name] themselves, and they are able to change their mind at any point without having to give a reason.

<https://forms.office.com/e/Q40jXHGZh4>

Please do not hesitate to contact me if you have any further questions.

Best wishes,

Megan Dixon  
Trainee Clinical Psychologist

## Appendix L: Parental Consent Form

### Parental Consent Form for Participants under 16



Consent form for parents/carers  
(Draft version 6.0: 30.03.2023)

Title of study: Adolescents' Views of Depression and Recovery

Primary Researcher: Megan Dixon, [megan.dixon@nottingham.ac.uk](mailto:megan.dixon@nottingham.ac.uk)

Supervisors: Anna Tickle: [anna.tickle@nottingham.ac.uk](mailto:anna.tickle@nottingham.ac.uk)

Faye Devlin: [fdevlin@lincoln.ac.uk](mailto:fdevlin@lincoln.ac.uk)

Rohan Naidoo: [mszrjn@exmail.nottingham.ac.uk](mailto:mszrjn@exmail.nottingham.ac.uk)

Name of parent/carer with parental responsibility who is consenting:

Name of participant (child):

Please initial box

1. I confirm that I have read and understand the information sheet version number 5.0 dated 02.03.2023 for the above study and have had the opportunity to ask questions.
2. I understand that my child's participation is voluntary and that they are free to withdraw within 1 week of the interview, without giving any reason, and without their care or legal rights being affected. I understand that I can also withdraw my child from the study under the same conditions. I understand that should they withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.
3. I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research [team](#) and regulatory authorities where it is relevant to the study. I give permission for these individuals to collect, store, analyse and publish information obtained from my child's participation in this study.
4. I agree for my child's data to be shared with other researchers in the future, [as long as](#) they are not identifiable from the data.
5. I understand that my child's personal details will be kept confidential.
6. I understand that my child's conversation with the researcher will be kept private unless the researcher is worried about their safety or the safety of someone else, or they are discussing the research with the other researchers involved with this project as detailed above. If the researcher is worried, they will tell the appropriate people and will try to inform my child about this, where possible.
7. I agree for my child (named above) to take part in the above study and for the researcher to contact them on the contact details provided below.
-

8. I would like my contact details to be kept on file so that I can be emailed a copy of the research findings.

\_\_\_\_\_      \_\_\_\_\_      Tick box for confirmation of  
Name of parent      Date      consent

\_\_\_\_\_      \_\_\_\_\_      Tick box for confirmation of  
Name of person taking consent      Date      consent

Participants contact details for researcher to arrange interview:

Phone: \_\_\_\_\_      Email: \_\_\_\_\_



## Appendix M: Assent form for participants under 16

### Assent Form for Participants under 16



Participant assent form  
(Draft version 6.0: 30.03.2023)

Title of study: Adolescents' Views of Depression and Recovery

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Your name:

Please tick box

1. I have read the information sheet and understand what taking part involves. I have been able to ask questions about the study and have them answered.
2. I agree to provide details of my location only for use in case of an emergency during interview.
3. I agree that my parent/carer can be contacted in case of an emergency during interview, using the details I previously provided.

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

Tick box to confirm  
assent

## Appendix N: Identification of charity webpage

**From:** Milly [REDACTED]  
**Sent:** 29 June 2023 13:27  
**To:** Megan Dixon <[msxmd19@exmail.nottingham.ac.uk](mailto:msxmd19@exmail.nottingham.ac.uk)>  
**Subject:** Re: [REDACTED] Research #68904] Research request documents

Hi Megan,

Thanks for the update and am glad to hear that recruitment is going well.

I have passed on the amended advert to the relevant team to upload to [REDACTED] so it should be live in the next week or so.

In relation to your question about [REDACTED], I'm afraid we don't have a specific page on [REDACTED] about depression. There are multiple different resources for young people on the platform, such as articles (written both by [REDACTED] community users and our professional team), discussion boards, mini-activities or chat with a practitioner. Apologies I can't be more helpful here.

Best wishes,  
Milly

## **Appendix O: Interview Schedule and Debrief**

### Introduction

Hello, my name is Megan Dixon and I am doing some research about how teenagers understand depression and recovery, based at the University of Nottingham.

- Thank you so much for taking part in this research with us.
- Our conversation today could be around 1 hour.
- We can take a break during the conversation if needed, and we can also have two separate sessions if you'd prefer.
- You can stop our conversation at any time, without telling me a reason why.
- Our conversation will be audio recorded.
- Do you have any questions about today?
- Can I confirm that you are happy to take part in this research?
- Current location in case of an emergency during interview (this will not be used unless there is an emergency during interview and will be destroyed after you take part):

Ice-breaker: how have you been feeling about our conversation today?

### Background information

- Age
- Gender
- How/where would you search for information about depression online?
- Have you had any contact with CAMHS? What was it? How long was it for?
- When did you first think you were experiencing depression? How did you know?

### Interview

- Symptomatic experiences
- What are your experiences of symptoms of depression?

- Physical symptoms? Behaviour changes? Feelings? Thoughts?
- What does depression mean to you?
- How would you describe depression?

### Causes

- What do you think caused your experience of depression?
  - Early experiences, life events, family history, biology
- Where did you learn about possible causes of depression?
- Parents, peers, education, social media

### Long-term coping

- How long have you experienced depression for?
- How do you think depression might affect you in the future?
- How do you cope with depression?
- What helps? What doesn't help?

### Impact

- How does depression impact you and your life?
  - Relationships, school/work, socialising, stigma, opportunities, functioning, identity
- Do you feel that there are any positives of experiencing depression?
  - Hopefulness, responsibility

### Recovery and outcomes

- What would recovery from depression look like to you?
- What would be different?
  - Thoughts, feelings, behaviours, sense of identity
- What are/were your expectations of support for depression?
  - Where did they come from? Parents, peers, education, social media/internet
- What would good support for depression look like?
- What would good support help with?
- What impacts whether support is good or not?

- Expectations/beliefs? Type of treatment? Practitioner factors?  
Service factors?
- What could make support for depression better?

Is there anything else related to depression or mental health, and how you make sense of it, that would be relevant to discuss today?

#### Debrief

- After the interview the researcher may discuss some of the following points with the participant:
  - How are you feeling after the interview?
  - Check thoughts of self-harm or suicide if mentioned throughout interview.
  - Is there anything that you would like to discuss that the interview has brought up for you?
  - The conversation we have had today may have been difficult for you. Some people find it useful to do something for themselves after conversations like this, e.g., to relax. Do you think this would be helpful for you?
- Participants will be signposted to the charity they were recruited from, their parents, or other support charities.

If any concerns have been raised in the interview or throughout the debrief, the researcher will take appropriate action in line with local safeguarding policies. If the participant is under 16, the individual with parental responsibility who provided informed consent will be contacted if deemed necessary and appropriate. Should any issues arise, the researcher will also discuss this with their supervisors. The participant will be talked through the debrief sheet (see below) and will be sent a copy via email for their future reference.

## Appendix P: Transcription Conventions

Transcription Symbols (taken from Potter & Hepburn, 2005)

[ ] Square brackets mark the start and end of overlapping speech. Position them in alignment where the overlap occurs, as shown below.

↑↓ Vertical arrows precede marked pitch movement, over and above normal rhythms of speech. They are for marked, hearably significant shifts \* and even then, the other symbols (full stops, commas, question marks) mop up most of that. Like with all these symbols, the aim is to capture inter- actionally significant features, hearable as such to an ordinary listener \* especially deviations from a common sense notion of 'neutral' which admit- tedly has not been well defined.

Underlining Signals vocal emphasis; the extent of underlining within individual words locates emphasis, but also indicates how heavy it is.

**CAPITALS** Mark speech that is obviously louder than surrounding speech (often occurs when speakers are hearably competing for the floor, raised volume rather than doing contrastive emphasis).

°I know it° 'degree' signs enclose obviously quieter speech (i.e., hearably produced – as quieter, not just someone distant).

(0.4). Numbers in round brackets measure pauses in seconds (in this case, 4 tenths of a second). Place on new line if not assigned to a speaker (i.e after a TRP)

(.) A micropause, hearable but too short to measure

((text)) Additional comments from the transcriber, e.g., context or intonation.

Ye::h Colons show degrees of elongation of the prior sound; the more colons, the more elongation. I use one per syllable-length.

Hhh Aspiration (out-breaths); proportionally as for colons.

.hhh Inspiration (in-breaths); proportionally as for colons.

Yeh, 'Continuation' marker, speaker has not finished; marked by fall-rise or weak rising intonation, as when enunciating lists.

Y'know? Question marks signal stronger, 'questioning' intonation, irrespective of grammar.

Yeh. Periods (full stops) mark falling, stopping intonation ('final contour'), irrespective of grammar, and not necessarily followed by a pause.

Bu-u- Hyphens mark a cut off of the preceding sound.

>he said< 'Greater than' and 'lesser than' signs enclose speeded-up talk. Sometimes used the other way round for slower talk.

Solid.== 'Equals' signs mark the immediate 'latching' of successive talk, whether of one or more speakers, with no interval

Sto(h)p i(h)t Laughter within speech is signalled by h's in round brackets

Uh um How to spell 'er' and 'erm' the Jefferson way.

## Appendix Q: Analysis example

26 started dealing with my friends problems and then i started to think

27 about how they applied to me and made a few realisations about myself

28 (that were maybe a little harsh at the time) not fitting in and [how i might

29 actually be impacting others and it made me more socially aware that

30 maybe i did have something the matter with me that people wouldnt like)

31 a lot of my symptoms that i was having i thought were completely

32 normal for kids my age at the time until then so it hit me like a ton of

33 bricks

34 Interviewer: ahh okay what sort of symptoms do you mean?

35 Emma: a few i can probably name in particular is when i stopped

36 wanting to take care of myself, not wanting to get up, losing energy to

37 want to do absolutely anything, i did start having suicidal ideation pretty

38 early on actually (that i didnt actually act on) and along with it i started

39 getting heavier anxiety symptoms too i started to fall behind in a few o

40 my classes too because i couldnt concentrate on them

41 Interviewer: how/when did you realise that these were symptoms of

42 depression?

43 Emma: my parents made me go to a doctor because i kept denying

44 that it was or that it was related but they were the ones to point it out

45 and thats when i was made to have a big discussion about it and how it

46 might be affecting me

47 Interviewer: ahh okay and how did it feel when that happened for

48 you and you sort of realised?

49 Emma: i didnt really believe it to be affecting me as much as i did to

50 be completely honest, i thought i was functioning fine and maybe i did

**Yellow Post-it Notes:**

- realisation
- importance of others
- out of the blue
- extreme
- sympathy
- blaming others, being told what to do etc.

**Handwritten Annotations:**

- discrain
- child-dependence, impact on/of system is important
- teenager discourse
- to care away blame
- normalises minimises
- from narrative
- but actually she thought these were normal
- of dep medical
- what's normal or not
- happened to me - fault away blame responsibility
- emotional & physical discourse
- metaphor to strengthen argument "physical"
- to have a strong emotional impact on someone
- self-blame
- physical
- list - exhaustive, demonstrative of severity with selection of symptoms
- self-blame
- separation of dep course
- child-dependent at the mercy of others
- at the mercy of others
- LACK OF POWER.
- assume she didnt realise even though not implied really - I am expert? she responds to this?
- was not normal - teenager
- protect from accountability
- depression about functioning

Key:

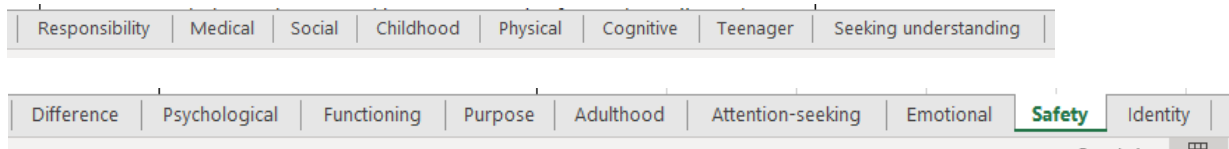
- Yellow post-it notes detail discursive effects from initial reading of the transcript



- Blue writing indicates discursive psychology-related analysis
- Green writing indicates Foucauldian Discourse Analysis-related analysis

Extracts of participant interviews and websites were then grouped by discourse, with discursive effects of the text, DP analysis and FDA noted.

These extracts were grouped into separate excel sheets:



Extracts and analysis were then re-examined, and discourses drawn upon by only a small number of participants were disregarded. Other discourses were pulled together. For example, upon re-examination the discourses of childhood, being a teenager, adulthood, and responsibility, reflected a transition to adulthood. The 'difference' discourse, on further examination, reflected social processes, and was therefore included as part of the social discourse. Once discourses were regrouped, the data included was continually analysed during write up, and the titles of the discourses reflected the discursive effects, action orientation, subject positionings, and other aspects of the analysis process. For example, instead of being named 'social discourse', the experience of the relational aspect for adolescents was used for the title 'disempowerment through relationships'. The extracts were grouped into these discourses on an excel spreadsheet, with examples below.

	A	B	C	D
1	Participant/Website	Quote	DP comments	FDA comments
	Alex	Its like being stuck with no motivation or anything and where you lock yourself in your room if like at home but when out and about around people your happy and having a good time because you dont want to reveal how you feel or maybe thats how you feel at the time but then it comes crashing down again and you feel burnt out so you just lock yourself away from everyone and yeah its a cycle	framed as a metaphor, but then describes it directly - is this a way of distancing from it, too painful? Self-blame, locks themselves away 'you don't want to reveal' suggests power, action, choice 'crashing down' is metaphor, sudden and powerful collapse physical connotations of burnout	isolation, social narrative, but also psychological narrative with the cycle
2	Alice	Interviewer: that's alright Alice I think I think I get what you mean so:: and so you said like motivation, self-esteem, is there anything else that was like (.) coming up wh-when you first kind of noticed that depression kind of (.) feeling? Alice: umm (.) probably like relationships at home Interviewer: oh ok yeah (.) what happened there? um just like (.) break downs in relationships with like my mum (.) so it's like just me and her and (.) but as I got older like that like relationship broke down but it was also made worse by the fact that I wasn't doing stuff (.) that I should have been doing because of like (.) my motivation and like I wasn't living up to her standards of me when I was younger like (.) my grades dropped and I wasn't as involved in dance anymore coz I didn't have the motivation to like oh I didn't feel that interest in it like I used to and I feel like cause of that then breakdown of relationship that also made it -worse	'as I got older' suggests a direct comparison between teenager and depression, relationships will change with teenagers, but worse with depression? Also teenager narrative with the fact that she wasn't doing things that she should have been doing, says who? And not living up to parents expectations, functioning narrative as well	I didn't have the motivation to like oh I didn't feel that interest in it lie I used to' - sounds medical, like she's regurgitating the DSM
3	Alice	Alice: Yeah I guess so um like u:h like maybe like when you're like (.) struggling with like fitting in with like friend groups and like um just like being yourself and stuff and then you've got that on top of it and it's like you just constantly telling yourself like (.) 'oh I'm not good enough I can't even get everyday things done I can't get myself to do this and do that and then when like I am out and I am doing this like that everyone's judging me and it makes me feel like quite um (.) -hopeless? I guess?	sense of being outcast, not fitting in? and at the end a sense of shame and defectiveness use of 'you' suggests a common experience sense of self-blame, maybe links to responsibility narrative that she can't do things - who has made her feel ashamed of this? uses a list of 3 to strengthen her argument here 'I guess?' implies uncertainty	social - importance of friendship groups in teenage years
4	Ceara	oh: (.) I guess like (.) basically that well for someone my age like not getting along with people or like (.) being around school feeling happy to-to get good grades or feel happy around my family I just didn't really feel that I (.) um (.) I just felt like (.) nothing really like mattered it was just me and I was just all alone with my thoughts and no one really understood them (.) and that's why I didn't really socialise like with um people because I just thought that they (.) wouldn't understand and it made me like really isolate myself from others.	indicates the importance of social life during adolescence 'someone my age' insinuates that she should be happy to get good grades list of 3 used	isolation narrative
5	Ceara	Interviewer: Why was like problems of socializing with people related to like depression? Ceara: oh:: because not being able-not feeling like I could count on anybody else because well my parents used to say some of that like that I shouldn't trust anyone else and like just like talk to them rather than talking to other people about my-myself and anything that I was feeling (.) I guess like (.) it relates to depression because (.) it was so hard being around people and talking to people about what I felt-it was something I really felt like I couldn't have because of my parents (.) so like the fact that I felt like I couldn't trust anyone else made me feel so lonely that I did feel really depressed growing up	problems with socialising according to who? Unable to trust 'anyone' repeated, emphasises isolation positioning herself as grown up now, 'while I was growing up'?	blame on parents lack of social safety leads to isolation and consequently depression
6				

Relationship disempowerment Embodiment marginalised Dismissed child, responsible Medical assumed, doubted

	A	B	C	D
40	<p>Millie: loneliness has been one of the biggest factors of my depression and for some reason that makes it harder to communicate</p> <p>idk</p> <p>i just feel like i dont have the energy to communicate with myself let alone with others</p> <p>but i crave affection and intimacy and care, i just want someone to be there for me</p> <p>which is normal to some extent but when it is the driving factor of my depression for 4 years it's kinda concerning</p> <p>Interviewer: does living at home not help your depression then?</p> <p>Millie: no not really</p> <p>i love my parents and their support is lovely and we communicate much better than we used to but they're still so insanely overprotective and controlling which i can understand to some extent considering the shit i've done in the past but they take it to another level</p> <p>then again, i think living alone would prob be a million times worse bcs as i mentioned loneliness is like a whole other huge monster to me and a lot of the time it's bigger than the depression monster</p> <p>although they're kinda like conjoined twins or something</p> <p>whatever u know what i mean</p>	<p>- lack of choice, power, control, self-blame, links to how she described inviting the monster in, gives an image of surrendering to an external force</p>	<p>isolation</p>	
41	<p>Riya</p> <p>I think for me when I first started recognising it it was from (.) so: I was dating this boy yeah(h) (laughter) and from that point (.) when things happened with that person (.) u:m like when we broke up on and off for a while he went round-he dated me my name's Riya that he was dating me to get close to someone else and their name was also Riya? So: um yeah it was quite like (.) brutal(h) It was quite-it pissed me off i was u:h what 12? 13? A:and from that point i think my self-harm escalated, then i became very low in myself, had low self worth, and the only thing that was really keeping me going was my best friend, and then obviously we had a really huge falling out (.) and then after that the thing is even though we had that falling out yes now we're friends but that whole falling out brought me down and i think they were sort of my early signs i would say</p>		<p>best friend as protective factors, loss of that relationship -&gt; depression</p>	
42	<p>Riya</p> <p>obviously you're not born with anxiety and depression that is (.) i would say personally i feel it's an environmental thing because (.) nobody is-no child can be born depressed that it sort of (.) it-it's a condition that is (.) it's a i would say it's almost a man-made condition people make people feel a certain way, people say things to people which make them feel a certain way, people do things to make them (.) depressed but that's a whole debate in itself u:m (.)</p>	<p>list of 3 included, persuasive/emphatic – starts off protecting herself from accountability, then ends up presenting all of this as fact – also positions people with depression as lacking power, bit of an 'us and them'</p>	<p>Rejecting biomedical model in favour of social discourse</p>	
43	<p>Riya</p> <p>Riya: because it all adds up because it was (.) i would say it's like -being depressed is sort of it's different to just feeling "sad it's this constant feeling of sadness and isolation and it's something you really can't get rid of</p> <p>Interviewer: mm</p> <p>Riya: and well i-it's potential you can get rid of it but even so nobody really tries to help you (.) get rid of it (.) and i think (.) that's really difficult in terms of: i like people don't really (.) help people to (.) cope with it and get through it</p>	<p>this is generalised, as though it's the standard experience</p>	<p>lacking power need power from others</p>	
44	<p>Riya</p> <p>Riya: and this like-it links to depression because it's the actions of people that causes (.) depression cause like (.) it's-it's like a state of like (.) it's like a -basically a state of low mood (.) do you get what i mean? So it's like (.) what causes this low mood because i had a great childhood my parents like (.) i: was the first one i was i was born through IVF-yeah me and my parents argue, yeah we have our issues, but: (.) like for -example i don't know any mum? who just gives their daughter: £50 to go into town just (.) randomly you know .hh for example (.) -yesterday m-my dress cost 90, my shoes cost 40, then my hair and makeup that was 60 then my: u:m today my nails was-is gonna be about 50-then yesterday i had wax my arms under arms and face-full face and neck that was £39 (.) she was about to buy me my- the car but that was £350 and "nobody is gonna spend that but it's like (.) you know i needed a screen protector next day delivery screen protector came and she sorted it out Interviewer: Yeah</p> <p>Riya: it's like (.) it's clearly not coming f-eyes you know my brother he can be an absolute (.) horrible person who does make me feel very depressed and low in myself because he says things like oh (.) just go kill yourself oh (.) just do this and i would say (.) my parents try and deal with that but it can be difficult for them bu-but we're working on it we've got MST involved, and teams involved, but i would say: (.) the trigger point is other people (.) because if you think about it (.) it's other people who make you feel bad about yourself</p>	<p>common sense, she says it quickly</p>	<p>social narrative, blame in others,</p>	
45	<p>Sinead</p> <p>Sinead: Like anyone who is different on the internet like as we know it doesn't usually go (.) very well for them hh (.) it's kind of like this-this like gang mentality like in (.) say like a comments section if one person says something negative (.) the whole comment section will be negative, making fun of someone's appearance their behaviour something like "that</p> <p>Interviewer: Yeah yeah so it feels like yeah like you said that it's all everyone kind of ganging up on that other person</p> <p>Sinead: [yeah]</p> <p>Interviewer: [mm] what do you mean by being- someone that's different? You said about like if anyone that's different (.) how does that relate to you or what do you mean by that?</p> <p>Sinead: within like my personal context it would be like a video of someone who's like ohh i haven't brushed my teeth in six months i'm finding it really difficult and then all the comments would be harassing them instead of encouraging them</p> <p>Interviewer: mm (2.0) so (.) like you mean it's different (.) because that's not what everyone agrees with or</p> <p>Sinead: yeah because it's not like what is considered like (.) the normal</p> <p>Interviewer: ok (.) so in-in that sense you how how would you view kind of people who experienced depression in terms of being different or being normal? Where does that sit? How you know what do you think about about that?</p> <p>Sinead: (1) u:m hh (2) i feel like people are trying to kind of normalise depression</p>	<p>as we know' assumed, inclusive, everyone – minimises harm 'doesn't usually go very well for them' – also 'them', not including herself in this, 'them vs us', protecting herself from this identity because it's painful? Later swaps the group she belongs to, becomes the 'understanding' group</p> <p>them and us' again, but this time positioning herself as</p>	<p>no power to achieve it, but also assumes that it is seen as different/shameful if it needs normalising in itself</p>	

## Appendix R: Joanna Briggs Institute Qualitative Assessment and Review Instrument self-appraisal



### JBI Critical Appraisal Checklist for Qualitative Research

Reviewer Megan Dixon Date 26.01.2024

Author _____	Year _____	Record Number _____			
		Yes	No	Unclear	Not applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there congruity between the research methodology and the research question or objectives?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there congruity between the research methodology and the methods used to collect data?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there congruity between the research methodology and the representation and analysis of data?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there congruity between the research methodology and the interpretation of results?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a statement locating the researcher culturally or theoretically?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the influence of the researcher on the research, and vice-versa, addressed?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are participants, and their voices, adequately represented?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Appendix S: Joanna Briggs Institute Qualitative Assessment and Review Instrument independent appraisal**

## JBI CRITICAL APPRAISAL CHECKLIST FOR QUALITATIVE RESEARCH

Reviewer Millie Crouch Date 03/02/24

Author \_\_\_\_\_ Year \_\_\_\_\_ Record Number \_\_\_\_\_

	Yes	No	Unclear	Not applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there congruity between the research methodology and the research question or objectives?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there congruity between the research methodology and the methods used to collect data?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there congruity between the research methodology and the representation and analysis of data?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there congruity between the research methodology and the interpretation of results?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a statement locating the researcher culturally or theoretically?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the influence of the researcher on the research, and vice-versa, addressed?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are participants, and their voices, adequately represented?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## POSTER

# Adolescents' Views of Depression and Recovery: A Discourse Analysis



Megan Dixon, Dr Anna Tickle, Dr Rohan Naidoo & Dr Faye Devlin  
Trent Doctorate in Clinical Psychology



## Background

Depression is most often first diagnosed during adolescence<sup>1</sup>. Alongside sociocultural changes, diagnosis rates have increased considerably in recent years<sup>2</sup>. Adolescents seem to conceptualise depression and recovery differently to mental health services<sup>3</sup>, and they lack social power to challenge this<sup>4</sup>. Incorporating adolescents' conceptualisations into support that is offered could reduce the power imbalance between adolescents and mental health services.



## Objectives

1. How do adolescents conceptualise depression and recovery?
2. How are depression and recovery conceptualised on websites widely accessed by adolescents?
3. How do adolescents' and websites' conceptualisations compare?

## Method

**Data:** 12 adolescents experiencing depression completed a semi-structured interview and were given a £10 voucher. 10 websites were identified. **Procedure:** Participants were recruited via social media and mental health charities. Websites were identified by Google or participants. **Analysis:** Recorded interviews were transcribed including linguistic features. Data were analysed using a combination of Discursive Psychology and Foucauldian Discourse Analysis<sup>5</sup>.



## Results

Four primary discourses were drawn upon by adolescents in their conceptualisations of depression and recovery:

- Medical discourse assumed but doubted
- Disempowerment through relationships
  - From isolation to connection
  - Positioned as different
- Physical embodiment is a marginalised narrative
- From dismissed child to responsible adult.



Some of these discourses were reflected within the website data, but emphasis often differed. Websites and participants both position adolescents as disempowered within their experience of depression and position this power with others, or the experience of depression itself.

## Discussion

Adolescents' use of medical language did not represent their medical conceptualisation of depression and recovery. Recovery was primarily seen as representing an increase in responsibility, in the context of adolescents' transition to adulthood.

**Limitations:** Naturally occurring data is preferred for discourse analysis. Efforts were made to reduce the power imbalance within the interviews. Only one participant was under the age of 16.

**Implications:** Adolescents should be empowered by mental health services, schools and caregivers. For example, through less objective criteria for mental health services. Non-medicalised approaches to prevent experiences of depression could improve relational skills and reduce experiences of isolation and therefore depression.

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