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COMPREHENSIVE REVIEW

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The lived experience of adolescent depression: A systematic review and meta-aggregation

Eve Twivy | Miriam Kirkham | Myra Cooper

Oxford Institute of Clinical Psychology Training and Research, Oxford Health NHS Foundation Trust, University of Oxford, Oxford, UK

Correspondence
Myra Cooper, Isis Education Centre, Warneford Hospital, Headington, Oxford, OX3 7JX, UK.
Email: myra.cooper@hmc.ox.ac.uk

Abstract

Background: The under-detection of depression in adolescents suggests that a better understanding of its presentation may be needed. Conceptualizations of adolescent depression are largely the same as adult depression, with minimal consideration of developmental stage. Exploration of first-hand accounts could help to identify any unique features of adolescent depression. Therefore, this systematic review aimed to understand the lived experience of adolescents with depression to inform clinical practice.

Methods: The review was registered with PROSPERO (CRD42020198141). Databases (PsychINFO, CINAL, MEDLINE and EMBASE) were searched in March 2022 to identify peer-reviewed qualitative studies on first-hand experiences of adolescent depression. The Joanna Briggs Institute's qualitative data extraction tool and checklist for qualitative research were used to obtain study data and assess methodological quality of included papers. Meta-aggregation was the method of synthesis, whereby extracted themes from the papers were grouped according to shared meanings.

Results: Fifteen papers of mixed methodological quality were identified for inclusion from screening a total of 1,983 references. Studies were published between 2002 and 2021, spanned seven countries and included participants aged 11 to 22 years old. Aggregation of 56 themes resulted in 16 categories and 3 synthesized findings encompassing key aspects of adolescent depression: causes, symptoms and coping. Variability in adolescents' perspectives across these domains was evident. Some symptoms described, such as social disconnection and anger, are not listed in existing diagnostic criteria.

Conclusions: Subjective experiences of depression among adolescents vary and may not entirely match diagnostic criteria. Awareness of this when assessing for depression may improve detection and help to ensure adolescents feel understood.

KEYWORDS
adolescence, depression, experience, meta-aggregation, qualitative, systematic review

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1 | INTRODUCTION

Adolescence is a time of rapid developmental changes that confer vulnerability to the onset of mental health problems (Rapee et al., 2019). Thirty-four per cent of adolescents worldwide are estimated to have raised depressive symptoms (Shorey et al., 2022). Depression is associated with increased risk of suicide, which is a leading cause of death in young people (World Health Organisation, 2021). Adolescent depression also has long-term consequences for health, social and educational outcomes (Clayborne et al., 2019). Whilst the detrimental impact of untreated adolescent depression is evident, it is frequently undetected (Fazel & Stein, 2015; Kramer & Garralda, 1998; Mullen, 2018). A better understanding of the symptoms and contributory factors may help to improve detection of adolescent depression.

The conceptualization of unipolar depression (i.e., depressive disorders), according to the criteria set out in the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5; American Psychiatric Association, 2013) and the International Classification of Diseases-11 (ICD-11; World Health Organization, 2022), is largely the same in adolescents and adults. Symptoms include low mood, anhedonia, appetite changes, psychomotor changes, fatigue, impaired concentration or thinking abilities, suicidal ideation, worthlessness, hopelessness and sleep problems (American Psychiatric Association, 2013; World Health Organization, 2022). The only difference for adolescents is that DSM-5 recognizes irritability as an alternative symptom to low mood (Bernaras et al., 2019). Although research indicates that adult criteria can be applied to adolescents (Pearce, 1978; Roberts et al., 1995), differences in frequency of symptoms according to age have been identified (Carlson & Kashani, 1988; Nardi et al., 2013; Rice et al., 2019). For example, physical symptoms (e.g., fatigue) were found to be more common in adolescents, whilst anhedonia and concentration difficulties were more common in adults (Rice et al., 2019). Furthermore, the use of measures and clinical interviews based on diagnostic criteria in quantitative studies imposes constraints on whether any qualitative differences in symptoms of adolescent depression are captured.

A review of theories regarding the onset and maintenance of adolescent depression found that current understanding draws primarily from adult models (Bernaras et al., 2019). The lack of adolescent-specific aetiological models of depression thus mirrors the lack of adolescent-specific diagnostic criteria. The main psychological theories applied to adolescents are cognitive-behavioural models and interpersonal models (Méndez et al., 2021). A negative cognitive style (Beck, 1979) and relationship disturbances (Weissman & Markowitz, 2002) are thought to contribute to the onset and maintenance of depression in each of these theories, respectively, which has been supported by some empirical findings (McCarty et al., 2007; Weersing et al., 2017). However, a review found that psychological therapy benefits were smaller for adolescents than adults with depression (Cuijpers et al., 2020); thus, there may be age-related aetiological differences (Rice et al., 2019).

Key Practitioner Message

- Depression in adolescents is frequently undetected.
- This review suggests that the subjective experiences of adolescents with depression do not fully map onto existing diagnostic criteria.
- Practitioners should be aware of the potential differences in presentation of adolescent and adult depression.

Although there has been some support for the application of conceptualizations and aetiological models of adult depression to adolescents, this top-down approach has limitations. Notably, the lack of attention to the influence of developmental stage has received criticism (Bernaras et al., 2019). It has long been recognized that adolescents are not simply smaller versions of adults when it comes to understanding and treating physical health conditions (Larcher, 2015). Due to biological, social and cognitive differences between adolescents and adults, this is likely to also apply to mental health conditions (Weiss & Garber, 2003). In order to identify any unique aspects of adolescent depression, beyond existing conceptualizations and models, a bottom-up approach is needed.

Qualitative research has the potential to advance our understanding of adolescent depression. There is increasing recognition of the value in obtaining service user perspectives in healthcare research (Al-Busaidi, 2008); it enables us to learn from people with lived experience, i.e., first-hand experiences of a phenomenon (Given, 2008; Manen, 1990). Furthermore, aggregation of qualitative studies (i.e., meta-aggregation) allows one to go beyond individual studies and make recommendations to inform practice (Lockwood et al., 2020). By collating the subjective experiences of adolescents with depression, it could inform assessment practices (Flanagan et al., 2010) and ultimately improve detection of depression.

A previous qualitative systematic review on the topic of adolescent depression identified features that are not captured in diagnostic criteria, such as a sense of disconnection from self and others (Dundon, 2006). It could be argued that this was because the review included papers with participants who did not have depression themselves or were not diagnosed with depression. A further limitation of this review was that it did not appraise study quality. Additionally, further qualitative research on adolescent depression has been conducted since 2006; thus, a more recent review is warranted. Given differences in the specific aims and methodology, a new protocol was developed for the current review as opposed to being a simple update of Dundon's review. The current systematic review aimed to:

- Gain an understanding of the lived experience of adolescent depression, i.e., first-hand experiences of developing and living with depression.
- Assess the quality of qualitative studies exploring adolescents' experience of depression.

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- Generate recommendations for practice, particularly with regards to detection of adolescent depression.

2 | METHODS

This systematic review used the Joanna Briggs Institute (JBI) approach to meta-aggregation (Lockwood et al., 2015; Lockwood et al., 2020). The underpinning philosophy of meta-aggregation is pragmatism; i.e., the practical usefulness of findings is considered central to this methodology (Hannes & Lockwood, 2011). This matched the review aims to produce recommendations for practice based on the lived experiences of adolescents with depression. The review was prospectively registered with PROSPERO (CRD42020198141), where the protocol can be accessed (crd.york.ac.uk/prospero/). The review was reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021), where these were applicable to a meta-aggregation of qualitative studies. A reflexivity statement from the authors is provided in Appendix S1.

2.1 | Study eligibility

2.1.1 | Types of participants

This review included papers with an adolescent sample, which was defined as an age range of 10–19 years (World Health Organisation, n.d.). Provided the mean age was within the 10–19 age range, samples up to 24 years old were included to allow for more recent conceptualizations of adolescence (Sawyer et al., 2018). Participants were required to have a diagnosis of unipolar depression. Co-morbid mental health diagnoses were permitted to reflect the high rates of comorbidity in clinical practice (Rohde, 2008). For mixed samples, papers were only included where the analysis was separate for adolescents with depression. Papers were excluded if the sample were selected on the basis of having a physical health condition or drawn from a perinatal population.

2.1.2 | Phenomena of interest

This review included papers that explored the lived experience of depression (i.e., experiences of features, symptoms, causes, consequences, impact, coping or social support). Papers were excluded where the focus was predominantly on experiences related to contact with services (i.e., experiences of formal help-seeking, diagnosis, treatment, intervention or recovery).

2.1.3 | Context

The review only included papers written in English, but there were no restrictions on geographical location.

2.1.4 | Types of studies

This review included studies that utilized a recognized qualitative methodology and were published in a peer-reviewed journal. Studies with samples that were retrospectively reporting on experiences (i.e., participants no longer had depression) were excluded.

2.2 | Search strategy

PsycINFO (via OVID), CINAHL (via EBSCO), MEDLINE (via OVID) and EMBASE (via OVID) were searched. These are deemed the major databases for health-related research and qualitative studies (Booth, 2016). Variations of search terms related to adolescent, depression and qualitative research were used for the keywords and subject headings (see Appendix S2). The search strategy was informed by literature on search strategies (Aromataris & Riitano, 2014; Booth, 2016), text and keywords in papers on adolescent depression, and consultation with a librarian. Preliminary searches were completed to obtain a balance between specificity and sensitivity of terms. Searches were initially conducted on 7 August 2021 and rerun on 1 March 2022 to identify new studies since the initial search. There was no restriction on publication date.

2.3 | Study selection

The study selection process is illustrated in Figure 1 using the PRISMA diagram (Page et al., 2021). The initial and updated database searches resulted in a total of 4,044 references. References were exported to Endnote X9, and 2,066 duplicates were removed. Subsequently, 1,978 references were exported to an Excel database for screening against the inclusion and exclusion criteria. First, screening of title and abstracts was completed. Pilot screening was conducted by the first reviewer (ET) and second reviewer (MK) on 30 references to test the criteria. Additionally, MK independently screened 25% of references from the initial search. Inter-rater reliability, calculated using Cohen's kappa, was moderate ($k = 0.46$; Altman, 1990). Therefore, screening criteria were refined. A further 10% of references were screened by MK, resulting in a near perfect agreement ($k = 0.90$). Disagreements were discussed, and any disputed papers went through to full text screening. In total, 1,862 papers were excluded at this stage, resulting in 116 papers. The most common reasons for exclusion were the paper not utilizing a qualitative methodology and the paper not exploring the lived experience of depression. The full text of one paper could not be accessed and thus was excluded.

Subsequently, 115 papers were assessed for eligibility via full text screening. Authors of papers were contacted where insufficient information was provided. Pilot screening was conducted by the reviewers on five papers. Additionally, the second reviewer (MK) independently screened 20% of the papers from the initial search, and there was perfect agreement ($k = 1.0$). In total, 101 papers were excluded at this

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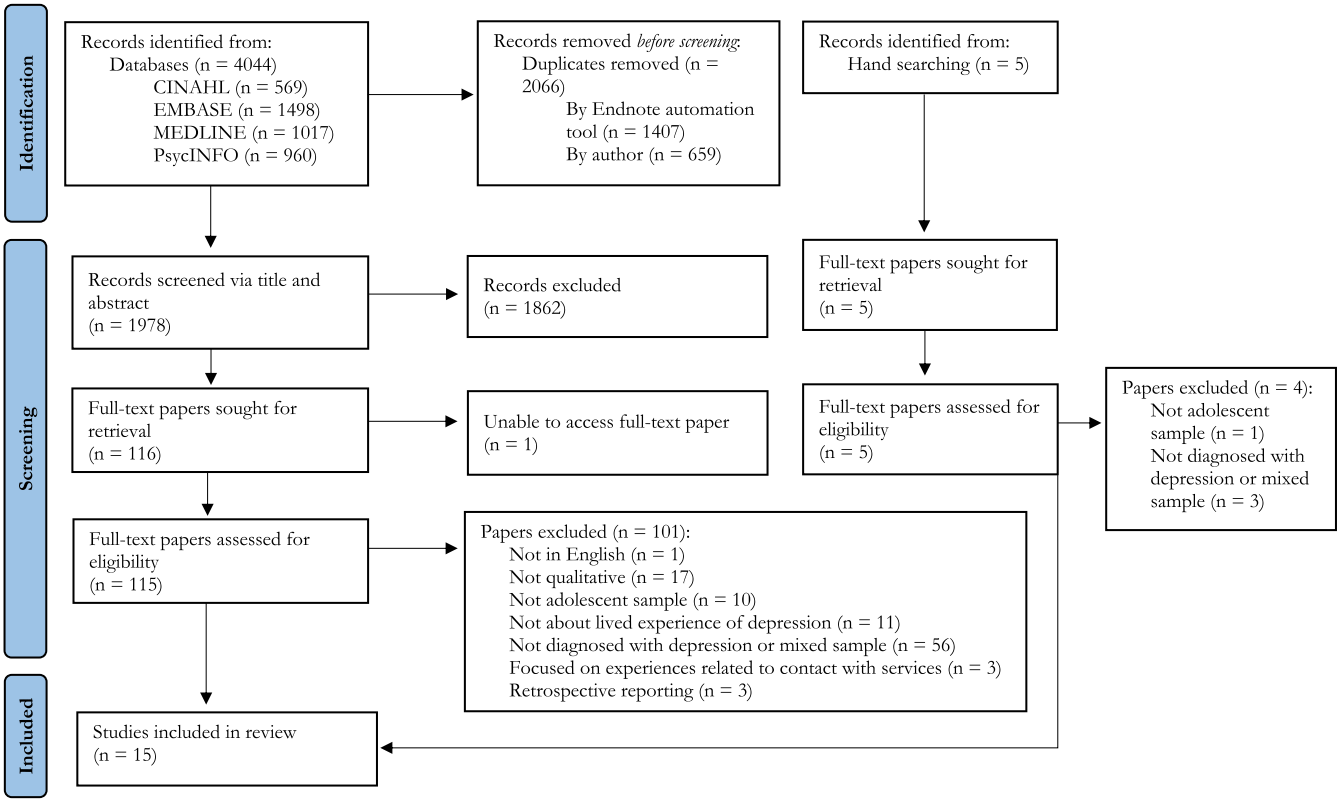


FIGURE 1 PRISMA diagram of study selection process

stage, with primary reasons for exclusion reported in Figure 1 (Liberati et al., 2009). Fourteen papers were identified for inclusion via the database searching. Reference lists of these papers were scanned to identify any additional studies. This resulted in one further paper for inclusion, thus bringing the total to 15.

2.4 | Quality appraisal

The methodological quality of studies was critically appraised using the JBI checklist for qualitative research (Joanna Briggs Institute, 2017; Lockwood et al., 2015). This has been compared favourably to other tools, especially with regard to its focus on assessing methodological congruence (Hannes et al., 2010). The checklist also evaluates reflexivity, ethics, interpretive validity and accuracy of conclusions. It was decided that no studies would be excluded on the basis of quality, both in order to conduct a comprehensive review in a relatively novel area and because setting a cut-off level seemed somewhat arbitrary. The checklist was piloted on two papers by the reviewers. Additionally, the second reviewer (MK) independently completed quality appraisal on five papers. Cohen's kappa indicated good agreement ($k = 0.63$; Altman, 1990). Quality criteria were refined, and a further two papers were independently rated by MK, resulting in near perfect agreement ($k = 0.86$). Discrepancies in ratings were resolved through discussion or via the third reviewer (MC).

2.5 | Data extraction

Data were extracted from papers using the JBI data extraction tool (Lockwood et al., 2020) (which is accessible via jbi-global-wiki.refined.site/space/MANUAL/4687826/Appendix+2.3%3A+JBI+Qualitative+data+extraction+too). This included information on aims, methodology, methods, analysis, participants, context and conclusions. Findings were also extracted. Findings were defined as themes or categories presented within the results section of included papers (Lockwood et al., 2020). Where there were sub-themes, findings were extracted at the major theme level to minimize overlapping concepts (Braun & Clarke, 2013) and ensure roughly equal weightings of findings across papers. Each finding was assigned a credibility rating in accordance with how well the findings were supported by a participant quote (Lockwood et al., 2015, 2020). Unequivocal findings were those where the accompanying quote clearly and explicitly supported the theme without question. Credible findings were those where the accompanying quote partly supported the theme or was somewhat ambiguous. Unsupported findings were those where the quote did not support the theme or no quote was provided (Hunter et al., 2019; Lockwood et al., 2020). Where multiple quotes were presented, the quote most closely aligned with the finding was rated (Hunter et al., 2019). The second reviewer (MK) independently performed data extraction on seven papers to ensure accuracy. Discrepancies in credibility ratings were resolved through discussion or via the third reviewer (MC).

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2.6 | Data synthesis

NVivo software was used to facilitate meta-aggregation of the included findings. Categories were developed through aggregation of two or more findings that shared a characteristic or meaning (Lockwood et al., 2020). Some findings were placed in more than one category due to encompassing multiple components. For example, a "low mood" category was formed from findings such as "Misery, despair, and tears" (Midgley et al., 2015, p. 272) and "Dispirited Weariness" (Farmer, 2002, p. 573). The latter finding also formed part of a "fatigue" category. Subsequently, categories were grouped to form three synthesized findings (Lockwood et al., 2020) representing key features of the lived experience of adolescent depression. For example, both the "low mood" and "fatigue" categories were conceptualized as "symptoms".

3 | RESULTS

The characteristics and methodological appraisal of the included studies are presented below, followed by the results from the meta-aggregation.

3.1 | Study characteristics

The extracted characteristics for the 15 studies are presented in Appendix S3. The studies were published between 2002 and 2021 and covered seven different countries: USA ($n = 5$), UK ($n = 4$), Australia ($n = 2$), Germany ($n = 1$), Canada ($n = 1$), Belgium ($n = 1$) and Latvia ($n = 1$). All studies explored the lived experience of adolescents with depression. Seven studies had narrowed aims, such as exploring perspectives on social support (McCann et al., 2012b), interpersonal relationships (Elsina & Martinsone, 2020), beliefs about causes of depression (Midgley et al., 2017), the role of social media (Radovic et al., 2017), the role of social representations (de Mol et al., 2018) and specific experiences of rumination (Oliver et al., 2015) and sleep problems (Jernslett et al., 2021). Some studies had a particular cultural stance, including understanding the experience of Black adolescents in rural areas (Hannor-Walker et al., 2020) and African American adolescents in an inner city (Ofonedu et al., 2013).

Nine studies used phenomenology as the overarching methodology (de Mol et al., 2018; Farmer, 2002; Hannor-Walker et al., 2020; McCann et al., 2012a, 2012b; Ofonedu et al., 2013; Oliver et al., 2015; Weitkamp et al., 2016; Woodgate, 2006). One study used a grounded theory approach (Wisdom & Green, 2004), and another used a qualitative description approach (Radovic et al., 2017). Four studies did not specify a specific qualitative methodology and adopted theoretically flexible methods of framework analysis (Midgley et al., 2015, 2017) and thematic analysis (Elsina & Martinsone, 2020; Jernslett et al., 2021). All studies used interviews for data collection.

Across the studies, sample size varied from 5 to 77 participants, and ages ranged from 11 to 22 years. Studies had more females than males, reflecting gender differences in depression prevalence rates (Hankin et al., 2015). Whilst all papers stated that participants had a diagnosis of depression, a minority gave specific details. Diagnoses specified included depressive episode (Elsina & Martinsone, 2020; Weitkamp et al., 2016), recurrent depressive disorder (Elsina & Martinsone, 2020), moderate to severe depression (Midgley et al., 2015, 2017) and major depressive disorder (de Mol et al., 2018; Jernslett et al., 2021).

3.2 | Methodological quality

Table 1 provides the quality appraisal ratings of studies. The questions (Q1–Q10) in the checklist for qualitative research (Joanna Briggs Institute, 2017) are located on the JBI website (jbi.global/critical-appraisal-tools). For question 8, the reviewers decided that adequate representation of voices would require a minimum of two quotes per theme at the major level. A paper (Parkinson et al., 2016) outlining the methodology adopted by Midgley et al. (2015, 2017) was used to inform quality appraisal decisions for these papers.

Individual papers ranged from satisfying 40% to 100% of the questions on the quality appraisal tool. A collective strength was that all studies except one (Hannor-Walker et al., 2020) had a clear relationship between the data and conclusions drawn. A further strength was the congruence between the methodology and interpretation of results for most studies. The two studies that did not meet this criterion did not state an overarching methodology or philosophical perspective, which may have been influenced by the fact that they were secondary analyses of data (Elsina & Martinsone, 2020; Jernslett et al., 2021). Whilst these papers used the theoretically flexible method of thematic analysis, a specific stance should have been adopted and stated (Braun & Clarke, 2013). Consequently, all the questions about congruence with the methodology were rated as unclear for these papers. The other studies largely had good congruence between the methodology and research question, data collection and analysis. The inconsistencies that existed included addressing a causal question (de Mol et al., 2018), use of data saturation (McCann et al., 2012a, 2012b), inter-rater reliability checks (Oliver et al., 2015) and positivist content analysis (Hannor-Walker et al., 2020) all within the context of interpretive phenomenology. A further inconsistency was the use of purposive sampling in a grounded theory study (Wisdom & Green, 2004).

An area of weakness across the papers was situating the researcher and addressing their influence on the research. Even for the 53% of studies that did provide theoretical or cultural attributes of the researcher, the information tended to be brief, such as stating their job role. Furthermore, only 33% of studies addressed the influence of the researcher, such as using a bracketing interview or reflexive log (de Mol et al., 2018; Farmer, 2002; Hannor-Walker et al., 2020; Jernslett et al., 2021; Midgley et al., 2017).

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TABLE 1 Quality appraisal ratings

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total (/10)
McCann et al. (2012b)	Y	Y	N	N	Y	N	N	Y	Y	Y	6
McCann et al. (2012a)	Y	Y	N	Y	Y	N	N	Y	Y	Y	7
Weitkamp et al. (2016)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9
Farmer (2002)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9
Woodgate (2006)	Y	Y	Y	Y	Y	Y	N	N	Y	Y	8
Hannor-Walker et al. (2020)	Y	Y	Y	N	Y	Y	Y	N	Y	U	7
Midgley et al. (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Ofonedu et al. (2013)	Y	Y	Y	Y	Y	N	U	Y	Y	Y	8
Radovic et al. (2017)	U	Y	Y	U	Y	Y	N	Y	Y	Y	7
Midgley et al. (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8
Oliver et al. (2015)	Y	Y	Y	N	Y	N	N	Y	Y	Y	7
De Mol et al. (2018)	U	N	Y	Y	Y	Y	Y	Y	Y	Y	8
Jernslett et al. (2021)	U	U	U	U	U	Y	Y	Y	Y	Y	5
Wisdom and Green (2004)	U	Y	N	Y	Y	N	N	N	Y	Y	5
Elsina and Martinsone (2020)	U	U	U	U	U	Y	N	Y	Y	Y	4
% yes	67	80	67	60	87	53	33	80	100	93	72

Abbreviations: N, no; U, unclear; Y, yes.

3.3 | Synthesized findings

It was noted that McCann et al. (2012a, 2012b) drew on the same overall dataset and Midgley et al. (2015, 2017) drew on the same overall dataset. However, the papers had different aims, the themes were informed by distinct areas within the datasets and there was no overlap in participant quotes used. Therefore, findings from all these papers were included. Sixty-four findings were initially extracted from the 15 papers. Six findings were excluded due to not being relevant to the review question as they focused on experiences related to contact with services. Two findings were excluded due to being unsupported by any participant quotes. The resulting 56 included findings are displayed in Appendix S4 with credibility ratings. As displayed in Figure 2, aggregation of findings resulted in 16 categories, which were further aggregated into three synthesized findings.

3.3.1 | Synthesized finding 1: Causes (i.e., making sense of why depression arose)

Eleven findings and three categories contributed to the first synthesized finding. Adolescents expressed varying perspectives regarding the causes of their depression. The category with the most findings was "environmental influences", indicating that many adolescents identified events and contextual factors that contributed to depression. A range of challenging life experiences were described. This included traumatic experiences (e.g., abuse, neglect, domestic violence, bullying and physical health complications), family challenges (e.g., conflict, parental physical or mental illness and parental separation), transitions (e.g., leaving school, exams, moving country and being taken into care) and losses (e.g., death of someone close, relationship breakups and becoming homeless; de Mol et al., 2018; Farmer, 2002; Hannor-Walker et al., 2020; Midgley et al., 2017; Ofonedu et al., 2013; Wisdom & Green, 2004). These experiences were linked to feelings of inadequacy or anger by some (Midgley et al., 2017): "I have lot of hate in my heart about everything that happened" (Ofonedu et al., 2013, p. 100). Wider societal views and pressures were also identified as being influential, such as expectations that they should be happy as a teenager (Wisdom & Green, 2004) or should be in a romantic relationship (de Mol et al., 2018). When these expectations were not met, it contributed to depressive symptoms.

In the process of trying to understand why they became depressed, some adolescents focused on "internal causes" including genetic factors, personality and individual responses to stressors (de Mol et al., 2018; Midgley et al., 2017). This could result in a sense of personal failure and self-blame: "I sorta brought it upon myself" (Midgley et al., 2017, p. 31).

Causes were not always known, and a common experience was that depression was "Hard to make sense of". Some adolescents were unsure why they had become depressed and didn't understand what they were going through (McCann et al., 2012a; Midgley et al., 2017): "I only know that I, well, suffer constantly, but why, I don't know" (Weitkamp et al., 2016, p. 6). This confusion could cause considerable distress (Weitkamp et al., 2016) and frustration (Midgley et al., 2017).

3.3.2 | Synthesized finding 2: Symptoms (i.e., perceived psychological, physical and social features of depression)

Thirty-three findings and eight categories contributed to the second synthesized finding. Adolescents with depression described varied

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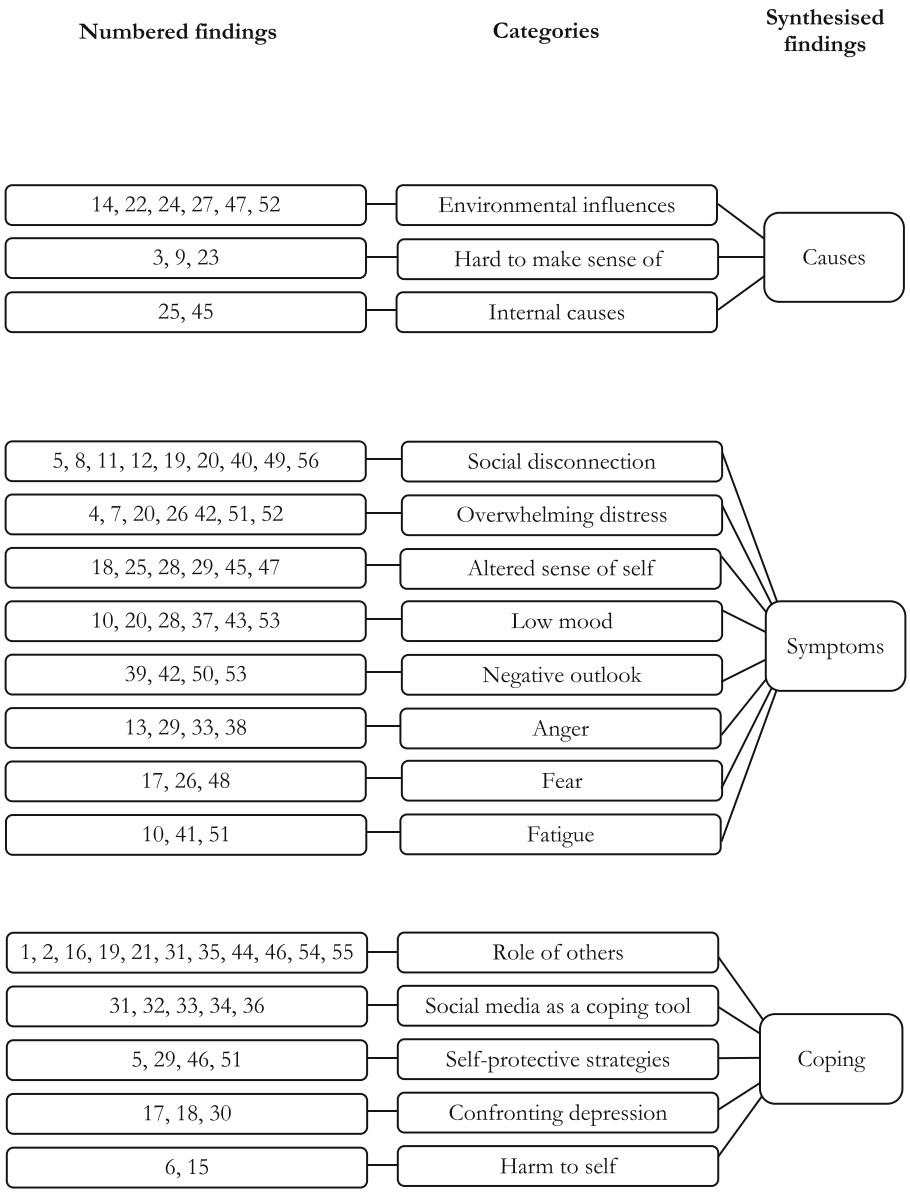


FIGURE 2 The aggregation of findings into categories and synthesized findings

psychological, physical and social symptoms. The category with the most findings was "social disconnection", which encompassed social withdrawal and isolation: "you want to isolate yourself and you don't actually want to be a part of all the normal things" (McCann et al., 2012a, p. 337). This could be in the form of physical separation, which could be due to being excluded by others (Midgley et al., 2015). Additionally, some chose to be on their own (Farmer, 2002; McCann et al., 2012a) due to tiredness, academic demands (Elsina & Martinsone, 2020) or fear of harm from or towards others (Hannor-Walker et al., 2020; Midgley et al., 2015). Emotional distance was created by not feeling understood (Midgley et al., 2015; Weitkamp et al., 2016; Woodgate, 2006), lack of affection from or towards others (Farmer, 2002; Midgley et al., 2017) or not disclosing difficulties (Elsina & Martinsone, 2020). The latter could be due to stigma, mistrust or concerns about being a burden (Elsina & Martinsone, 2020; McCann et al., 2012a; Weitkamp et al., 2016). Some described isolation leading to feelings of loneliness (Hannor-Walker et al., 2020; Weitkamp et al., 2016): "you feel like you don't have anybody" (Farmer, 2002, p. 574). Additionally, societal views on the importance of social connectedness could further exacerbate distress (de Mol et al., 2018).

"Altered sense of self" was another feature of depression experienced by adolescents. Disruptions in daily life tasks could result in adolescents feeling different to their normal self or to others (Ofonedu et al., 2013; Woodgate, 2006). Aspects of their identity could be threatened or lost: "People can lose their athletic side or their literature side or their schooling side" (Woodgate, 2006, p. 265). Adolescents also described feeling bad about themselves, such as feeling like a failure or inadequate (de Mol et al., 2018; Midgley et al., 2017; Ofonedu et al., 2013). This could be influenced by perceived opinions of others: "I think that people think that I'm not capable to have a relationship" (de Mol et al., 2018, p. 6).

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Adolescents also described experiences consistent with "low mood". Sadness was commonly described (Hannor-Walker et al., 2020; Midgley et al., 2015; Oliver et al., 2015) and was often prolonged: "It's just like the wind, sadness, and it's just smacking you and smacking you" (Ofonedu et al., 2013, p. 100). This could be felt in the body as a heaviness (Wisdom & Green, 2004), with descriptions such as "dragging feeling" (Midgley et al., 2015, p. 273). Sadness appeared to result in frequent crying and poor motivation (Farmer, 2002; Midgley et al., 2015; Ofonedu et al., 2013; Wisdom & Green, 2004).

Low mood seemed to coexist with a "negative outlook" on life (Wisdom & Green, 2004). Some adolescents talked about having repetitive negative thoughts or images about the past or future (Midgley et al., 2015): "Well there's nothing good to look back on. Is there anything good to look forward to?" (Oliver et al., 2015, p. 5). This could interfere with sleep (Jernslett et al., 2021). Indeed, "fatigue" was another symptom described by adolescents. A major impact of this was academic difficulties due to problems with oversleeping and concentration (Farmer, 2002; Jernslett et al., 2021): "I can never get up so I am always late for school … when I am in lessons I don't concentrate and then I - you know I get really behind" (Midgley et al., 2015, p. 275).

In addition to sadness, adolescents talked about having "a short fuse" (Midgley et al., 2015, p. 274), such that "anger" was a common emotion. It could be felt towards self or others: "I hated myself … I hated them, them being the rest of the world" (Farmer, 2002, p. 576). Some found it helpful to express anger by ranting on social media (Radovic et al., 2017). Anger could also be expressed through aggression towards family and teachers, such as shouting, throwing objects or hitting (Farmer, 2002; Midgley et al., 2015; Ofonedu et al., 2013). Aggression could also be directed inwards through self-harm (Midgley et al., 2015). For some, this aggression appeared to arise out of feelings of vulnerability (Ofonedu et al., 2013). Others noticed that the aggression made them feel worse about themselves (Midgley et al., 2015).

Adolescents' distress could worsen as depression progressed (Wisdom & Green, 2004) resulting in "overwhelming distress". Immense and relentless suffering was evident when depression was likened to "a heart ripping apart" (Ofonedu et al., 2013, p. 100), a "black hole" (Weitkamp et al., 2016, p. 4) and "a pit where you just can't get out anymore" (McCann et al., 2012a, p. 337). Facing symptoms could be "a disorienting battle" (Oliver et al., 2015, p. 5) leading to feelings of helplessness and hopelessness (Jernslett et al., 2021; McCann et al., 2012a).

Given the level of suffering, it is unsurprising that adolescents described "fear" in the context of depression. This included concerns that negative emotions would be ceaseless and stop them having a good future (de Mol et al., 2018). Some adolescents talked about having moments when they felt happy and problems felt more manageable (Ofonedu et al., 2013; Woodgate, 2006). However, a sense that depression "is waiting in the shadows" (Woodgate, 2006, p. 264) led to considerable anxiety about things deteriorating again. Indeed, relapse was described as part of living with depression (Ofonedu et al., 2013).

3.3.3 | Synthesized finding 3: Coping (i.e., positive and negative ways of responding to depression)

Twenty-three findings and five categories contributed to the third synthesized finding. Adolescents described both positive and negative forms of coping and social support. The "role of others" in coping with depression was commonly mentioned (Farmer, 2002; McCann et al., 2012b). Some adolescents talked about helpful support from family, partners, friends, teachers and online communities (Elsina & Martinsone, 2020; McCann et al., 2012b; Radovic et al., 2017). This included actual or desired experiences of people recognizing difficulties, being understanding, being available to talk and listen, remaining in regular contact, helping with daily tasks and suggesting activities (Elsina & Martinsone, 2020; Farmer, 2002; McCann et al., 2012b; Woodgate, 2006). Some adolescents described how sharing thoughts or feelings with others could be helpful: "I get up and go and tell my mum that I'm thinking like that and she'll calm me down" (Oliver et al., 2015, p. 8).

Conversely, some adolescents spoke about an absence of social support (Hannor-Walker et al., 2020): "I get nothing (support) from my parents and my friends. I try to explain to what degree it is, and it scares them" (McCann et al., 2012b, p. 457). Experiences included being excluded by peers, lack of communication or involvement from parents, receiving criticism or verbal aggression, academic pressures and the failure of others to recognize depression or take it seriously (De Mol et al., 2018; Elsina & Martinsone, 2020; Farmer, 2002). Some adolescents described how unhelpful interactions could negatively impact coping. For example, family arguments could trigger rumination (Oliver et al., 2015) and encountering others' posts about risky behaviour on social media could lead to urges to engage in these behaviours (Radovic et al., 2017).

In addition to the role of others in coping, adolescents described their own personal ways of responding to depression. This included "self-protective strategies" that aimed to protect themselves from difficult emotions and the world. Concerns about stigma, judgement and bullying led to some adolescents being aggressive (Ofonedu et al., 2013) or hiding their depression (de Mol et al., 2018; McCann et al., 2012b): "I have programmed myself not to show any sadness at that school because they will take it and eat it up" (Ofonedu et al., 2013, p. 100). Furthermore, oversleeping could be a way to escape from the painful reality of depression (Jernslett et al., 2021). Adolescent's also described ways that "harm to self" could occur in response to depression. Risky behaviours existed on a spectrum and included cutting, drug and alcohol misuse, risky sexual behaviour and suicide attempts (Farmer, 2002; McCann et al., 2012a). These actions could reflect apathy or ways of escaping emotional distress: "I don't really have a place to lead a productive life so let's just end it" (Farmer, 2002, p. 578).

Some adolescents described using "social media as a coping tool", which could be helpful or unhelpful (Radovic et al., 2017). Social media could be an outlet to express feelings, look at positive or funny posts or gain social support: "they would tweet at me and say, "Are you okay? Text me if you need anything."" (Radovic et al., 2017, p. 7) However, social media use could also result in negative social comparisons and judgement from others; thus, adolescents were more careful with their use over time (Radovic et al., 2017).

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A positive form of coping described by adolescents was "confronting depression". This includes acknowledging their difficulties, doing enjoyable activities, holding onto happy moments (Ofonedu et al., 2013) and trying to "look on the bright side" (Woodgate, 2006, p. 265). Some adolescents expressed that they wanted to get better but were also fearful of things getting worse (Ofonedu et al., 2013; Woodgate, 2006).

4 | DISCUSSION

This systematic review primarily aimed to understand the lived experience of adolescents with depression. Meta-aggregation of results from 15 qualitative studies resulted in three synthesized findings. These represent adolescents' perspectives on causes, symptoms and coping within the context of depression. Each synthesized finding is considered in relation to existing literature and implications for clinical practice. The quality assessment findings are also discussed.

4.1 | Causes

Adolescents' accounts of the causes of their depression varied; however, negative environmental circumstances were commonly mentioned. This is aligned with wider literature on the association between adverse childhood experiences (ACEs) and an increased risk of mental health problems, including depression (Nelson et al., 2020). The inclusion of two papers in this review that specifically focused on experiences of Black adolescents may have contributed to the prominence of this topic, given that this population is at greater risk of experiencing ACEs (Hicks et al., 2020). The negative life events reported by adolescents largely comprised of challenging relational experiences, thus corresponding with theorized triggers around transition, grief and conflict within the interpersonal model of depression (Weissman et al., 2017). Failing to meet societal expectations of a "normal" adolescent also appeared to feed into depression, thus indicating a need to consider systemic influences at a broader level too. Some adolescents referred to personal characteristics (e.g., personality) that caused their depression, which could result in self-blame. Thus, it may be important for practitioners to attend to the meanings adolescents attach to causes of depression.

Whilst some adolescents could identify causes, this review highlighted that a common subjective experience was confusion about why they were depressed. Given that this could result in considerable distress, it is important for practitioners to be aware that asking adolescents questions about the onset of depression may require sensitivity, patience and exploration. Furthermore, it is important for practitioners themselves to be aware of the risks factors as indicated in guidelines by the National Institute for Health and Care Excellence (NICE, 2019).

4.2 | Symptoms

Individual differences in depressive symptoms were evident from this review, as has been found in other research (Manfro et al., 2021; Nardi et al., 2013). Many experiences described by adolescents were analogous to core symptoms within DSM-5 (American Psychiatric Association, 2013) and ICD-11 (World Health Organization, 2022) criteria, including low mood and fatigue. Additionally, hopelessness was evident in the "negative outlook" and "overwhelming distress" categories, and worthlessness was captured in the "altered sense of self" category. In relation to the latter, adolescents appeared to describe a broad impact on their identity because depression interfered with daily life tasks. Indeed, a quantitative study found that adolescents with depression viewed themselves more negatively than controls across varied domains such as academic ability, sports and appearance (Dozois et al., 2012). Thus, sense of self might be particularly important for practitioners to pay attention to, as is indicated in cognitive therapy (Beck, 1979). Given that adolescence is a time of identity development (Erikson, 1994; Mahler et al., 1975), the significance of self-concept is understandable.

Some depressive symptoms listed in diagnostic criteria were absent from the results of this review. There were infrequent references to difficulties concentrating at school, with little mention of broader difficulties with thinking ability. Additionally, whilst there were occasional descriptions of poor motivation and apathy, anhedonia was not explicitly described by adolescents. Indeed, a quantitative study found that both anhedonia and impaired concentration were less common in adolescents than in adults (Rice et al., 2019). The minimal reporting of anhedonia by adolescents is particularly significant, given that it is one of the two core symptoms, alongside low mood, in DSM-5 and ICD-11 criteria. Appetite and psychomotor changes were also rarely mentioned in the studies included in this review but have been reported in quantitative research with adolescents (Orchard et al., 2017; Rice et al., 2019). It may be that adolescents do not link these specific symptoms to depression. Discrepancies in findings could also be explained by individual variation; thus, assessment of a variety of symptoms is likely needed to inform individualized treatment targets.

This review further adds to our understanding of adolescent depression by capturing features that are not part of diagnostic criteria. One of the most common experiences described was social disconnection. This was in the form of physical or emotional isolation, which could result in loneliness. Indeed, another systematic review identified a cyclical relationship between loneliness and depression in young people (Achterbergh et al., 2020). Furthermore, loneliness was a central symptom of adolescent depression in network analyses (Manfro et al., 2021; Mullarkey et al., 2019). The impact of social disconnection may be especially significant during adolescence given the importance of social acceptance and peer relationships (Blakemore, 2012; Pitman et al., 2018).

Another symptom described by adolescents was anger. Whilst irritability is captured within the DSM-5 criteria, adolescents' accounts indicated that this often progressed to anger. This could be felt very intensely and result in aggressive behaviours towards self or others. The prominence of anger in adolescent depression is supported by other research (Crowe et al., 2006; Hammen & Compas, 1994; Jackson et al., 2011; Manfro et al., 2021). Hormonal changes as a result of puberty may make adolescents more vulnerable to anger

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(Buchanan et al., 1992). However, it is important that where anger is persistent, it is not disregarded as typical adolescent mood swings (Dundon, 2006; Moreh & O'Lawrence, 2016).

Another important experience identified in this review was the immense suffering that adolescents with depression face. Adolescents indicated that this was not always recognized or understood by people in their lives (de Mol et al., 2018; Elsina & Martinsone, 2020; McCann et al., 2012b). This may partly reflect the fact that, historically, depressive symptoms were seen as a normal part of adolescence (Arnett, 1999). Not only could adolescents' suffering lead to hopelessness but also considerable fear about depression stealing their future. This may be understood in the context of their life stage: Existential concerns can arise as young people develop abstracting thinking abilities (Wadsworth, 1996) and transition to adulthood (Berman et al., 2006). Adolescents' accounts, in addition to evidence on the detrimental long-term impact of depression (Clayborne et al., 2019), clearly indicate that depression needs to be taken seriously.

The NICE (2019) guidelines suggest that detection of depression in adolescents should use self-report questionnaires and clinical interviews. Current assessment tools are largely based on diagnostic criteria, which, in light of this review, appear to match many but not all of the lived experiences of adolescents with depression. This review indicates it would be important for practitioners to consider additional features, such as social disconnection and anger, and assess the level of distress and fear with regards to symptoms.

4.3 | Coping

In relation to coping with depression, interpersonal influences were commonly described by adolescents. This adds to current literature indicating the importance of social support in outcomes for depression (George et al., 1989). The review findings suggest it is important for practitioners to assess support from family, friends and teachers, as this will likely impact on coping. Furthermore, it may be important to involve others in treatment, as is indicated in interpersonal therapy (Lipsitz & Markowitz, 2013). Interpersonal influences extended to the impact of social media, which appeared to encompass both positive and negative coping mechanisms. Given that social media has become so prominent in the lives of young people (Pew Research Centre, 2018), it may be helpful for practitioners to assess nature of social media use.

To manage concerns about stigma, adolescents described how they might hide their depression from others. Indeed, adolescence is time of heightened attention to social evaluation (Somerville, 2013). Thus, this should be held in mind by practitioners when assessing depression, and a trusting relationship may need to be built initially before young people feel comfortable to disclose (Georgakakou-Koutsonikou & Williams, 2017). Another way that adolescents tried to cope with distress was by harming themselves, which is well documented (Guerreiro et al., 2013) and supports the need for risk assessments. Adolescents also described helpful coping strategies they had developed independently; thus, it may be beneficial for practitioners to acknowledge the resilience and strengths that adolescents have.

4.4 | Quality assessment

The studies included in this review had mixed methodological quality, thus somewhat limiting the confidence in the review findings. However, only results that were supported by participant quotes were included in the meta-aggregation, thus helping to ensure that the synthesized findings were credible (Hannes et al., 2018). Whilst the methodological congruence of studies was largely good, there was generally a lack of reflexivity, which compromises the dependability of the studies. It also prevents the review from determining the lenses through which the results of the included studies were generated (Florczak, 2021). Future qualitative research on this topic would benefit from greater transparency in reporting the author's influence on the research. An updated review could be completed if new high-quality studies are published that have implications for the confidence in the review findings.

4.5 | Limitations

To ensure the review explored depression in a way that was useful for clinical services, only papers where adolescents had a depression diagnosis were included. However, this may limit the extent to which the findings capture early warning signs or aspects of depression beyond diagnostic criteria. Given that research evidence supports the view of depression as existing on a continuum (Bowins, 2015), it may be helpful for future reviews to synthesize the lived experience of elevated depressive symptoms to inform early recognition and prevention.

A further limitation of this review was having minimal studies that incorporated the experiences of depression in early adolescence (10–13 years old). This may reflect the onset of depression typically occurring from mid-adolescence (Malhi & Mann, 2018) or challenges conducting research with younger participants (Daelman et al., 2020). Given that rapid changes occur between 10 and 19 years old (Backes & Bonnie, 2019), stage of development within adolescence may influence the presentation of depression.

Investigating differences in depression based on demographics, including age, gender and ethnicity, was beyond the scope of this review. The meta-aggregative approach extracts themes at the study level, rather than findings at the level of the individual (Hannes & Lockwood, 2011). Given that most studies had samples with mixed age, gender and ethnicity, the review is unable to systematically explore the potential influence of individual-level characteristics on the lived experience of depression. Most of the included studies do not link participant quotes to detailed demographic data; thus, this would have been difficult to investigate even if a different synthesis approach had been used. Comparative studies on the lived experience of depression could be conducted in the future to assess any differences in themes according to age, gender and ethnicity.

5 | CONCLUSIONS

This review highlights that adolescents with depression experience considerable distress. Adolescents may be confused about what is

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happening to them and may try to hide their symptoms; thus, accurate assessment of depression could take time. This review also indicates that the symptoms described by adolescents with depression do not fully map onto diagnostic criteria, which are largely based on adults (Roberts et al., 1995; Weitkamp et al., 2016). Social disconnection and anger were described by adolescents but do not feature in diagnostic criteria. Conversely, anhedonia, impaired concentration, appetite changes and psychomotor changes barely featured in adolescents' accounts yet are part of diagnostic criteria. These findings add to research that has identified differences in the presentation of depression in adolescents compared to adults. To make progress in recognizing and understanding adolescent depression, there is a need to move away from viewing adolescents as smaller versions of adults.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this review article, as no new data were created or analysed. The data extracted from papers included in this review are provided in the supporting information.

ORCID

Eve Twivy https://orcid.org/0000-0001-6173-4153

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