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Dealing with overwhelming life situations - young people´s experiences of becoming depressed

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Abstract

Background: Depression is common and increasing in young people, who seem especially vulnerable, both in the probability of developing depression, and in the resulting negative consequences across the lifespan. Unfortunately, available treatments rarely lead to full remission and even in cases of remission relapse rates are high. Different explanatory models have been proposed, and research indicates a multifaceted etiology. The descriptive DSM-5 has low diagnostic validity in this age-group, especially for depressive disorders, and limited attention has been given to young people´s own experiences of becoming depressed. Hence, there is a risk of missing clinical information that is important for the therapeutic alliance and treatment.
Objective: This study aimed to explore young people's experiences of becoming depressed.
Method: A qualitative study was performed. Six participants with clinical depression, currently in treatment at child and adolescent psychiatric outpatient clinics in northern Sweden were recruited. Interviews followed a semi-structured manual, and data was analyzed with inductive qualitative content analysis.
Results: Participants described different reasons for their depression, and from their stories four categories were identified: "Being subjected to violence", "Suffering separation and loss", "Feeling abandoned", and "Feeling burdened and vulnerable". These categories were interpreted in the theme: "Dealing with an overwhelming life situation".
Conclusions: The participants presented mainly stressful external and relational events preceding their depression. A combination of overwhelming stressors, lack of support and lack of time for recovery was described. This points to the importance of validating the narratives of young patients with depression and to offer trauma-informed treatment approaches in mental health care.

Keywords: Young adults, adolescents, depression, qualitative research, personal narratives.

Introduction

Depression is one of the most common and most debilitating health problems of today (1). The etiology of depression has been ascribed to a multitude of factors and a dynamic interplay between them. They range from genetic factors (2) to more contextual socio-economic challenges, interpersonal stress (3), exposure to traumatic events (4) and social exclusion (5). Gender stereotypes and societal norms may also contribute to the onset of depression (6-11). Recent studies indicate that the incidence of depression is increasing in young people (12-14). From 2006 to 2018 self-reported mental distress in Sweden was highest among 16–29-year-olds, an age group that also showed the highest yearly increase of depression (15). Among people who develop their first depressive episode in adolescence the risk of subsequent depressive episodes is increased threefold (16). Early onset depression presents with high psychiatric co-morbidity and it is related to several negative outcomes such as substance abuse (17), poor academic performance (18) and suicide (19, 20).

It has been shown that the subjectively perceived reasons for getting depressed impact how patients manage their condition (21). The subjective understanding of the suffering and patients' narratives and meaning making impact both compliance to treatment and help-seeking behaviours (22, 23). Research has also highlighted how adults with depression perceive their depression onset, but less is known about young people. There is some evidence that young people attribute their difficulties to both negative environmental circumstances such as traumatic experiences and family challenges and internal factors including

genetic factors and personality (6, 7, 9). The literature also reports that some young individuals find it hard to make sense of their depressive symptoms and hence are unsure of why they became depressed (6). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is applied as the principal authority on psychiatric diagnoses. It has low diagnostic validity in this age-group, especially for depressive disorders (24-27). The DSM-5 is based on signs and symptom criteria, it largely discounts the etiology of depression, and it neglects the subjective understanding of why a person gets depressed.
With this approach there is a risk of missing or minimizing important clinical information and both developmental and contextual factors may be crucial for therapeutic alliance and patient validation. In this qualitative study we wanted to make the voices of young people with depression heard.

Aim
The aim of this study was to explore young people's experiences of becoming depressed.

Methods
Design
A qualitative inductive design was used, and six individual semi-structured interviews were performed, transcribed verbatim and analyzed using qualitative content analysis (28, 29). The Consolidated Criteria for Reporting Qualitative Research (COREQ) guided this report.

Study context
The study was conducted with young people with major depressive disorder according to the DSM-5, who participated in a multi-center randomized controlled trial (RCT) that is conducted at child and adolescent psychiatric outpatient clinics and youth clinics in two county councils in northern Sweden. The RCT is investigating the relative effectiveness in treating depression with a novel intervention called Training for Awareness Resilience and Action (TARA) compared to standard treatment in a 1:1 allocation ratio. Only participants who were allocated to standard treatment were included in this qualitative sub-study. Interviewed participants received treatment mainly with selective serotonin reuptake inhibitors, CBT, and/or psychoeducation. The details of the RCT are fully outlined in the open-access-published trial-protocol (30) as well as in the study pre-registration on clinicaltrials.gov (NCT-registration identifier: *NCT04747340*).

Participants
Purposive sampling was chosen to reach participants willing to share their experiences. Four females and two males, aged 17-18 (median 17) years, with clinical depression were recruited from the standard treatment arm in the RCT. At the time, n = 19 participants were enrolled. All the approached individuals consented to be interviewed and all of them completed the interviews.

Procedure and data collection
Interviews were conducted by JÖ in February and Mars 2023. A semi-structured interview guide with open-ended questions was used. For example, questions like "Why did you think that you got depressed?", "How has your mood developed over time and what do you think the reasons are?", and "What is your experience of the treatment you have been offered?" were asked. To encourage participants to develop their stories, follow-up questions were asked. The focus was to explore young people's subjective understanding of why they got depressed.
The interviews were conducted over a secure online video platform and lasted for 38-58 min (median time 48 min). Interviews were audio recorded and transcribed verbatim by a professional transcriber. No repeat interviews were carried out and transcripts were not returned to participants for comments or corrections.

Analysis
The interviews were analyzed with inductive qualitative content analysis (28). Transcripts were first read several times separately by LR and JÖ to familiarize with the text and ensure that the interviews had been correctly transcribed. The material was then discussed to get an overall view of the data. Data was then divided into meaning units relevant to the aim of the study. Material derived from answers to leading questions and nonsense utterances was discarded at this stage. The meaning units were then condensed and labelled with codes by LR and JÖ. All authors then sorted the codes into groups according to their variations, similarities, and differences to create categories and subcategories. For example, codes such as "Not a huge stress, but an insecurity" and "Happy, lots of energy, talking, until my brother got sick and died" were grouped together with similar codes to form the subcategory "Loosing safety and important relationships", which was abstracted in the category "Suffering separation and loss", which was interpreted in the main theme "Dealing with an overwhelming life situation". Data was interpreted in a main theme to describe the connection between the categories and subcategories. The analysis resulted in nine subcategories, which were abstracted into four categories and interpreted in a theme, all presented in Table 1. The authors met regularly to discuss their interpretations, challenge assumptions, and reflect on

TABLE 1. Theme, categories and subcategories describing the participants experiences of becoming depressed.

Subcategories	*Categories*	*Theme*
Living in a threatening home environment Being bullied and abused	Being subjected to violence	Dealing with an overwhelming life situation
Losing safety and important relationships Being limited by health problems	Suffering separation and loss	
Lacking support from parents Being invalidated by professionals	Feeling abandoned	
Having too much responsibility for others Feeling pressure to do well in school Feeling lonely, inadequate, and fragile	Feeling burdened and vulnerable	

the analysis as well as the result in relation to the original data. The result was revised several times. All authors agreed upon the final structure. Participant validation was not undertaken. The analytic work was thus carried out through reflective dialogues and negotiation between the six authors. EE, MS, JM and EH all had experience of working in mental health care. They and LR had experience of conducting qualitative research in this area. EH was PI for the RCT from which participants were recruited and she developed the intervention tested in it. None of the researchers had any ongoing or previous clinical/other established relationship to any participant. The only information given to participants about the interviewer was his name and profession.

Ethical considerations

Ethical approval was obtained from the national ethical review board (D.nr 2020-05734 and 2021-06418-02) and participants had provided specific written informed consent for this sub-study when they consented to participate in RCT-study.
Selected participants were contacted over the phone to receive more detailed information about the present study. Participation was voluntary and participants were free to terminate the interview/study at any time point.

Results

Here follows an elaboration of the results presented in text, and codes are compared within and across categories/subcategories. Quotations are included to illustrate subcategories and support analytical claims. The quotations have been translated from Swedish to English [translator's clarifications are bracketed].

Dealing with an overwhelming life situation

Participants described a gradual buildup of depressive symptoms during long periods of stress. It was said that – *"It was just too much"*. Participants identified a multitude of factors as contributing to their depression rather that a single cause. Participants described experiences of being subjected to violence, suffering from separation and loss, feelings of being abandoned by family, school and health care, and feelings of being burdened and vulnerable. Taken together, participants appeared to be dealing with an overwhelming life situation.

Being subjected to violence

Participants described experiences of being subjected to physical, psychological and sexual violence and stated that this was a major driver of their depressive symptoms. Participants' experiences of violence had occurred in their home, in school, in relations with adults and with people of their own age.

Living in a threatening home environment

Participants experienced ongoing or previous domestic violence, including parental assaults directed to the participants themselves, the other parent and/or siblings.

> *"And he [the father] just kept hitting and hitting. My sister screamed at him to stop. Then he stopped, and I ran upstairs. He had a key ring which he threw at me while I ran up the stairs." (P6)*

Participants described that aggressive parents had made them feel anxious and on guard, even at times when the parent was in a good mood. Participants also described their parents as authoritarian and having rigid rules, which could lead to severe punishments if someone made a mistake.
Participants' experiences of being subjected to violence were said to make them feel ashamed, insecure, and depressed. Further, they stated that an abusive home environment had a negative impact on their social life as they didn't want to invite friends to their home.

Being bullied and abused

Participants described experiences of bullying and harassments, experiences that for some had been ongoing for long periods of time. Mostly, this kind of violence was said to occur in school by people of the same age, as a part of their everyday life. Participants also described having been sexually

abused as early as in elementary school and in destructive romantic relationships.

"I was sexually abused by my friend who was in my class at the time" (P4)

Experiences of not being secure with their peers were described. Participants said that they hung out with other people even if they felt like they were used for the others own benefit. Some found it hard to make new friends even if they wanted to.

"I don't know why they became so mean. I think… Like one class they were sitting in a group room with the popular guys, and they had ranked the girls on whoever was hottest and who was ugly. When they were ranking me one of the guys said I looked like a fish ass and that I was the ugliest. I felt hurt and became sad." (P6)

To not be treated well was said to make participants start to believe the negative things that were said about them. Participants expressed that this led to feelings of shame and low self-esteem, feelings they kept to themselves for long times and that made them depressed and low.

Suffering separation and loss

Experiences of separation and loss were described as reasons for participants' depressive symptoms, for example moving and losing their community and friends, parental divorce, the death of a close person, and loss of health and bodily functions.

Losing safety and important relationships

Participants described parental divorce and moving to a new area and/or changing school as stressful events. They expressed that they lost safety, routines and sometimes even the contact with close friends or parents due to the changes in their everyday life. This was said to contribute to depressive symptoms, especially when it happened repeatedly.

"I never got to feel settled. There was of course a sense of safety in each of the homes, but you never felt the comfort and security of staying in one place." (P5)

Participants had experienced family members and/or friends passing unexpectedly. This was described as difficult to handle and participants expressed feelings of shock as well as a sense that the world was not real. Furthermore, they expressed a fear that other loved one would also die. Sometimes it was said to be too much to handle, so instead emotions were completely turned off. Participants also described changes in their behavior, for example some found it hard to say goodbye. Some participants would panic when a family member was going away.

"And I know that this created demons in my inner world, like hell. I was like how could those be the last words? '- See you on Tuesday'. So, every time I said goodbye to someone I had to say; '- Goodbye, love you, take care'. Always after his passing [I did that]." (P3)

Participants furthermore stated that loosing important relationships had negatively affected them for long periods of time and that they had become low and depressed due to their loss.

Being limited by health problems

Experiences of being impacted and restricted in different ways due to health problems were described. For example, one participant said that a thigh injury made it hard to continue to exercise and play soccer.

"You could describe every injury as a little depression in itself. It's hard to know how the body is handling [the injury], until it snaps and gets bad. You kind of build your hope up between times, it feels better, you get stronger and then you need to begin from square one again. It has been hard in that way." (P2)

Participants described struggling with different mental health problems, for example anxiety. They described symptoms of anxiety leading to poor sleep and panic attacks, which in turn led to the onset or worsening of depression. It was furthermore said that panic attacks affected participants' ability to live a normal life; to be afraid of getting an attack with other people, was said to lead to isolation and low energy.

Participants also expressed that COVID-19 restrictions had forced them to stay at home for long periods of time, with no ability to go to school or hang out with friends. This was said to have had a negative impact on their mental health as it further increased the sense of isolation and inability to do things that participants were used to do.

Feeling abandoned

Participants expressed experiences of lacking support, of not being seen and even invalidated by society, as for example by health care and school personnel. They also described being misunderstood and not being taken seriously.

Lacking support from parents

Participants described recurring experiences where one or both parents did not understand their feelings or the severity of their condition. It was described that a parent could argue that there was no need to see a psychologist or seek help in other ways. The participants also described parents as being angry

with them for being low or inactive, which contributed negatively to their condition.

> *"I told my dad several times that I wanted to see a psychologist, but he only said that 'No, my children are perfect. They can't feel bad. What the hell are you seeing a psychologist for? You're fine.'" (P3)*

Furthermore, participants described parents as being too busy with their own lives and problems, without time to listen or engage with them, and in situations of shared loss parents had been unable to support participants due to their own grief. Participants expressed a need for parents that were more emotionally available.

Being invalidated by professionals

Participants described that they had been diminished and unseen by health care professionals, especially in child and adolescent psychiatry. When trying to explain their problems and feelings, participants expressed that the health care professionals did not understand the severity of their condition, and sometimes they were not interested in their story.

> *"It was really frustrating and terrible. I asked for help, which was already difficult enough, and then they [the clinicians at the child and adolescent psychiatric clinic] said that 'You have friends and no visible problems, so we won´t help you'. It really felt like my problems weren´t big enough, that THEY decided my feelings weren´t a problem. Like my feelings and what I´ve been through don´t count." (P1)*

Participants also described that they had had to wait for many months for treatment, which had contributed to their feelings of being insignificant and neglected. Participants also expressed negative experiences of the treatments that they had received. It was stated that antidepressants had been prescribed without a treatment plan or follow-up, and participants expressed confusion as to for how long they would continue the medication.

> *"There was almost no follow-up on the medication and no interest in the effects from prescribing doctors." (P2)*

This was also said to be the case with other treatments like psychotherapy. Experiences of not being taken seriously by health care professionals was said to have led to feelings of being stuck with no solutions or hope of getting better.

Participants also expressed being misunderstood and let down in school, with teachers and other school staff who did not listen to and/or misunderstood them.

> *"So, suddenly, all the teachers were against me too. Then later it became clear that what they said was completely incorrect and another student spoke up for me. But my school-life changed and a lot of teachers were still like; 'She's a bully, she is a bad child'." (P1)*

Participants expressed not having any adult in school that they trusted, and in conflicts with teachers they expressed lack of support from them and also being let down by the classmates, as if everyone took the teachers' side.

Feeling burdened and vulnerable

Participants expressed experiences of being burdened with responsibilities, pressures from others and high demands. Participants also described an inner fragility and alienation as contributing to their suffering.

Having too much responsibility for others

Participants expressed a necessity to take on too much responsibility for others. One participant from an immigrant family had to take care of the younger siblings and translate for the parents:

> *"It affects me. Like, on my birthday I sometimes think; 'God, now I have to plan everything, so it turns out well for everyone else', instead of it turning out well for me. Do you understand? So, I think more of how things will affect my family and how I should divide them at the dinner table to avoid problems." (P2)*

The participants also expressed that they felt responsible for other people's wellbeing in a more general way and that they tried their best to avoid conflict. This was said to have made them give up their own needs to help family and friends. As a result, participants described not being in touch with their own feelings and needs. Some said that they were too focused on others to be able to listen to and take care of themselves properly. Additionally, participants stated that there was no pause, rest, or recovery possible.

> *"I think that there was a lot that built up during the years until I finally reached the breaking point basically, and then everything set loose. I think there were events in my history and a big reason that I developed depression was that I reached the breaking point." (P4)*

Feeling pressure to do well in school

Participants, including participants that were already doing quite well, described a constant pressure to achieve high grades in school,

> *"People would describe me as ambitious. I don't feel very ambitious, but that's what people describe me as, because I always try to do my best. I always try to be*

one of the best. However, that is very hard when I can't even get to school. Then it becomes a factor that results in more stress and depression." (P1)

The pressure was said to come from parents, school/teachers, and/or themselves. Participants described perceived failures, which created self-doubt and low mood. A downward spiral was described in which the low mood and lack of energy made it difficult to study, which further perpetuated the situation.
Participants also described their homework as stressful, *"too much"*, and that it made them feel anxious and unable to relax. Participants struggling with dyslexia expressed that they had experienced a really hard time in school before getting their diagnosis, and a need to work so hard that they became exhausted.

Feeling lonely, inadequate and fragile
Participants also described that no one had really cared for them and that they felt insignificant or not at all important. This was said to be very painful and created feelings of loneliness, sadness, and shame.

"Family, teachers, siblings, friends. I feel like I am not a special person to anyone." (P6)

Some participants said that they did not fit in among family and/or friends. They felt like they had to pretend to be someone else to be accepted and that they had to wear different "masks" when being with other people. This pretending was said to be very exhausting and generate a feeling of loneliness.
On top of that, participants described themselves as fragile and expressed an "inherent" tendency to worry and ruminate.

"Ever since I was little, my father would describe me as very like, how should I describe it? I have tended to worry all the time." (P4)

They described this fragility as a reason for their depression and expressed a wish for "a stronger self". Participants furthermore argued that having a more confident personality and higher self-esteem would have protected them from blaming themselves for everything that happened, and that to understand that not everything was in their control would have protected them from getting depressed.

Discussion
This qualitative study aimed to explore young people's experiences of becoming depressed. Semi-structured interviews were performed to gain an increased understanding of the perspectives of young people with depression in Sweden. Our study suggests that the young people in our sample attribute their depression to several reasons that have been presented in the different categories. We interpret the participants descriptions to indicate that they were dealing with an overwhelming life situation. The results are in accordance with previous publications, where contextual factors such as childhood trauma (e.g. abuse, domestic violence and bullying), family challenges (e.g. parental illness and parental separation), and losses (e.g. death of loved ones and relationship/friendship breakups) have been described as contributing to depression in young people (2-4, 6, 31). Previous studies have also identified individuals that ascribe symptoms to biological factors (31), this was however not detected in our sample.
In our study participants described their depression as related to their relational context and to events and circumstances that they had been subjected to, and not just a randomly appearing mental disorder. This is in line with recent research indicating that contextual factors systematically outperform neural metrics in predicting adolescent depression (32). The categories "Being subjected to violence", "Suffering separation and loss", "Feeling abandoned", and "Feeling burdened and vulnerable" all reflect such contextual circumstances. Only the subcategory "Feeling lonely, inadequate, and fragile" contained codes related to internal factors, and still this subcategory reflected results of mainly contextual factors. Hence, the participants' understanding of why they got depressed was almost exclusively ascribed to stressful life events and their stories highlight the variety of struggles that young people with depression have had to deal with in their everyday life. Participants described the presence of e.g., violence, neglect, bullying and having too much responsibility, and placed the blame for their depressive symptoms on these events and circumstances. In addition to these stressful contextual factors, the participants also described a lack of support. Both the category "Feeling abandoned" and the subcategory "Feeling lonely, inadequate, and fragile" reflected experiences of being alone and having no one to share problems and suffering with, and that was said to increase the suffering.
The way participants explained and interpreted their difficulties as related to stressful experiences is supported by research but not fully considered in the DSM-5 system (6, 33-35). Furthermore, the current clinical emphases on pharmaceutical symptom reduction and symptom management by e.g., cognitive behavioral psychotherapy do not give much consideration to the importance of previous stressful/traumatic events and how they affect the mental health of young people. With a diagnostic manual that focuses on only symptom criteria, rather

than etiology and the subjective experience and understanding of why a person gets depressed, it is unlikely that root causes to the depression will be effectively addressed in treatment.

The Power Threat and Meaning Framework (PTMF) from the British Psychological Society (36) challenges the diagnostic paradigm and highlights existing patterns of systemic power imbalances in the etiology of depressive symptoms. The framework is applicable to the experiences of young individuals with depression, and it provides a method to validate and empower affected individuals (37). The PTMF also emphasizes the subjective narrative and the importance of both individual meaning making and community support for resilience and healing. These are factors that have been shown to impact how patients manage their condition (21-23).

It is possible that young people's own experiences of their depression as related to major life events is not validated enough within the current diagnostic and treatment paradigms. Instead, the cause or even blame for the depression is at times placed on factors within the affected individual him/herself. Understanding young people's own experience could help build rapport and create a common meeting ground in which the young people's experiences and understandings are more ealisy validated. This would be in line with the fundamental principles of person-centered care where the personal narrative and building a therapeutic alliance and partnership are highlighted (38). As a result, the patient motivation to participate in treatment could improve, and so could patient empowerment.

In the present study the participants' reflections on their treatment highlighted a mismatch between what had been offered and what was hoped for and perceived as needed. Described low expectations were often based on negative previous treatment experiences, as described in the subcategory "Being invalidated by professionals". Participants described being diminished and unseen by health care workers and a lack of follow-up on antidepressant medication. The participants' views of therapy were similarly negative. Several participants stated that they had already talked to health professionals and others, and nothing had worked so far, and based on that experience the notion arose that nothing would help in the future either. All of this may have been a result of the fact that all participants were interviewed in a non-euthymic state. It is however consistent with previous research indicating that young individuals often have a negative view of psychiatric treatment and that other approaches than standard treatment may be needed (39). We argue that it is important to address the young people's own experiences and thoughts on the cause of their depression to build trust and improve treatment effects. If young individuals' own views of their condition are taken into consideration, potential discrepancies with the treatment offered can be acknowledged by clinicians. As a result, treatment alliance may improve and affected individuals may be given opportunities to discuss stressful life events, coping strategies, concerns and expectations. Further action research is needed in which the "users voices" are taken into consideration (40). One attempt to do so was to develop a treatment modality based on young people´s perspective is Training for Awareness Resilience and Action (30, 41), a trauma-informed twelve-week group intervention including emotional self-regulation skills training, empowerment strategies, and a socioecological approach. Future research will reveal if this model can address the issues described above and improve treatment outcomes.

Methodological discussion

Qualitative methods and semi-structured interviews were used to investigate young people's understanding of why they got depressed. Purposive sampling was chosen to meet the aim of the study and to strengthen the credibility and provide a varied and informative description (42). The representation of only two county councils in northern Sweden is a limitation, which might affect transferability (42). Including a total of six participants may be considered on the lower side. On the other hand, in qualitative research data is assessed based on its information power (43) and in our case we determined the data to be sufficiently rich and varied to elucidate the aim of the study (42, 43). Also, the interviews were long and the content rich. We do not claim that the results presented are exhaustive. However, the present results are in line with those of previous research synthesis on the causative process (37). In line with trustworthiness in qualitative research, we leave to the reader to decide if the results are transferable to their context. Triangulation between researchers with different competences and perspectives was used to strengthen the study's trustworthiness. More specifically, young and senior researchers (with an age range of 25 – 62), from backgrounds in medicine, nursing, physiotherapy, and pharmacy were involved in the analysis, which led to a mutual illumination of blind spots.

Conclusion

According to our results, relational and contextual factors and life situations are central to the experience of young people's depression. A combination of overwhelming stressors, lack of support and limited time for recovery was described. The results indicate that mental health care may benefit from elucidating and integrate young people's

individual experiences as has been done in several forms of psychotherapy, that are rarely offered within Child and Adolescent psychiatry of today in Sweden. To validate young individuals with depression and to meet their expectations and needs, new treatment modalities and support structures, including person-centered and trauma informed care, also need to be developed and tested.

Clinical significance

Psychiatric diagnoses are descriptive in nature although they are frequently depicted as causal explanations for symptoms (44). Overwhelming life situations appear to be perceived as contributing to symptoms. To actually listen to young people´s narratives and subjective perspectives and to address trauma may therefore be validating for affected individuals and it may also prevent re-traumatization by mental health services. Young people's understanding of why they got depressed is related to their motivation to participate in treatment and a shared understanding of the problem can improve clinical engagement and outcomes (21-23, 45). New approaches that empower and increase resilience to stressful life events are critically needed.

Conflicts of interest

None of the authors have any conflicts of interest to declare.

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References

1. Santomauro DF, Herrera AMM, Shadid J, Zheng P, Ashbaugh C, Pigott DM, et al. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. Lancet. 2021;398(10312):1700-12.

2. Shadrina M, Bondarenko EA, Slominsky PA. Genetics Factors in Major Depression Disease. Front Psychiatry. 2018;9:334.

3. Bear HA, Krause KR, Edbrooke-Childs J, Wolpert M. Understanding the illness representations of young people with anxiety and depression: A qualitative study. Psychol Psychother. 2021;94(4):1036-58.

4. Heim C, Newport DJ, Mletzko T, Miller AH, Nemeroff CB. The link between childhood trauma and depression: insights from HPA axis studies in humans. Psychoneuroendocrinology. 2008;33(6):693-710.

5. Slavich GM, Irwin MR. From stress to inflammation and major depressive disorder: a social signal transduction theory of depression. Psychol Bull. 2014;140(3):774-815.

6. Twivy E, Kirkham M, Cooper M. The lived experience of adolescent depression: A systematic review and meta-aggregation. Clinical Psychology & Psychotherapy. 2023;30(4):754-66.

7. Midgley N, Parkinson S, Holmes J, Stapley E, Eatough V, Target M. "Did I bring it on myself?" An exploratory study of the beliefs that adolescents referred to mental health services have about the causes of their depression. European Child & Adolescent Psychiatry. 2017;26(1):25-34.

8. Danielsson UE, Bengs C, Samuelsson E, Johansson EE. "My Greatest Dream is to be Normal": The Impact of Gender on the Depression Narratives of Young Swedish Men and Women. Qualitative Health Research. 2011;21(5):612-24.

9. Thapar A, Eyre O, Patel V, Brent D. Depression in young people. The Lancet. 2022;400(10352):617-31.

10. Strömbäck M, Wiklund M, Salander Renberg E, Malmgren-Olsson E-B. Complex symptomatology among young women who present with stress-related problems. Scandinavian Journal of Caring Sciences. 2015;29(2):234-47.

11. Åhlander A, Strömbäck M, Sandlund J, Wiklund M. Living (dys)regulated and alienated young masculinity—Young men's embodied experiences of mental disorders and suicidality. Counselling and Psychotherapy Research. 2023;23(4):893-905.

12. Lebrun-Harris LA, Ghandour RM, Kogan MD, Warren MD. Five-Year Trends in US Children's Health and Well-being, 2016-2020. JAMA Pediatr. 2022;176(7):e220056.

13. Mojtabai R, Olfson M, Han B. National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults. Pediatrics. 2016;138(6).

14. Twenge JM, Cooper AB, Joiner TE, Duffy ME, Binau SG. Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005-2017. J Abnorm Psychol. 2019;128(3):185-99.

15. Folkhälsomyndigheten. Nedsatt psykiskt välbefinnande[Internet] Stockholm: Hälsomyndigheten; 2020 [cited 2023 07-02]. Available from: https://www.folkhalsomyndigheten.se/fu-nedsatt-psykiskt-valbefinnande.

16. Johnson D, Dupuis G, Piche J, Clayborne Z, Colman I. Adult mental health outcomes of adolescent depression: A systematic review. Depress Anxiety. 2018;35(8):700-16.

17. Quello SB, Brady KT, Sonne SC. Mood disorders and substance use disorder: a complex comorbidity. Sci Pract Perspect. 2005;3(1):13-21.

18. Humensky J, Kuwabara SA, Fogel J, Wells C, Goodwin B, Van Voorhees BW. Adolescents with depressive symptoms and their challenges with learning in school. J Sch Nurs. 2010;26(5):377-92.

19. Bachmann S. Epidemiology of Suicide and the Psychiatric Perspective. Int J Environ Res Public Health. 2018;15(7).

20. Bertolote JM, Fleischmann A. Suicide and psychiatric diagnosis: a worldwide perspective. World Psychiatry. 2002;1(3):181-5.

21. Nunstedt H, Nilsson K, Skärsäter I, Kylén S. Experiences of Major Depression: Individuals' Perspectives on the Ability to Understand and Handle the Illness. Issues in Mental Health Nursing. 2012;33(5):272-9.

22. Bhui K, Bhugra D. Explanatory models for mental distress: Implications for clinical practice and research. The British Journal of Psychiatry. 2002;181(1):6-7.

23. O'Neill A, Humphrey N, Stapley E. A Systematic Review of Qualitative Research Focusing on Emotional Distress Among Adolescents: Perceived Cause and Help-Seeking. Adolescent Research Review. 2023;8(3):387-402.

24. Alexandrino-Silva C, Wang YP, Carmen Viana M, Bulhões RS, Martins SS, Andrade LH. Gender differences in symptomatic profiles of depression: results from the São Paulo Megacity Mental Health Survey. J Affect Disord. 2013;147(1-3):355-64.

25. Blom EH, Forsman M, Yang TT, Serlachius E, Larsson JO. Latent Classes of Symptoms related to Clinically Depressed Mood in Adolescents. Scandinavian journal of child and adolescent psychiatry and psychology. 2014;2(1):19-28.

26. BPS. Classification of behaviour and experience in relation to functional psychiatricdiagnoses: Time for a paradigm shift. DCP Position Statement. Leichester: The British Psychological Society; 2013.

27. Manfro PH, Pereira RB, Rosa M, Cogo-Moreira H, Fisher HL, Kohrt BA, et al. Adolescent depression beyond DSM definition: a network analysis. Eur Child Adolesc Psychiatry. 2021.

28. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105-12.

29. Lindgren BM, Lundman B, Graneheim UH. Abstraction and interpretation during the qualitative content analysis process. Int J Nurs Stud. 2020;108:103632.

30. Ekbäck E, Granåsen G, Svärling R, Blomqvist I, Henje E. Clinical Effectiveness of Training for Awareness Resilience and Action Online Compared to Standard Treatment for Adolescents and Young Adults With Depression: Study Protocol and Analysis Plan for a Pragmatic, Multi-Center Randomized Controlled Superiority Trial. Front Psychiatry. 2021;12:674583.

31. Ross E, Ali A, Toner B. Investigating issues surrounding depression in adolescent girls across Ontario: a participatory action research project. Can J Commun Ment Health. 2003;22(1):55-68.

32. De Lacy N, Ramshaw MJ, McCauley E, Kerr KF, Kaufman J, Nathan Kutz J. Predicting individual cases of major adolescent psychiatric conditions with artificial intelligence. Transl Psychiatry. 2023 Oct 10;13(1):314. doi: 10.1038/s41398-023-02599-9. PMID: 37816706; PMCID: PMC10564881.

33. Risch N, Herrell R, Lehner T, Liang KY, Eaves L, Hoh J, et al. Interaction between the serotonin transporter gene (5-HTTLPR), stressful life events, and risk of depression: a meta-analysis. Jama. 2009;301(23):2462-71.

34. Beardslee WR, Gladstone TRG, O'Connor EE. Developmental Risk of Depression: Experience Matters. Child and Adolescent Psychiatric Clinics of North America. 2012;21(2):261-78.

35. Kendler KS, Hettema JM, Butera F, Gardner CO, Prescott CA. Life event dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety. Arch Gen Psychiatry. 2003;60(8):789-96.

36. Johnstone L, Boyle M. The Power Threat Meaning Framework: Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled Or Troubling Behaviour, as an Alternative to Functional Psychiatric Diagnosis: British Psychological Society; 2020.

37. Ekbäck E, Rådmark L, Molin J, Strömbäck M, Midgley N, Henje E. The Power Threat Meaning Framework: a qualitative study of depression in adolescents and young adults. Front Psychiatry. 2024 May 1;15:1393066. doi: 10.3389/fpsyt.2024.1393066. PMID: 38757135; PMCID: PMC11097657.

38. McCormack, B., & McCance, T.V. Developing of a framework for person-centred nursing. Journal of Advanced Nursing, 2006; 56(5), 472-479.

39. Westberg KH, Nyholm M, Nygren JM, Svedberg P. Mental Health Problems among Young People-A Scoping Review of Help-Seeking. Int J Environ Res Public Health. 2022;19(3).

40. Bradbury H, Lifvergren S. Action research healthcare: Focus on patients, improve quality, drive down costs. Healthc Manage Forum. 2016;29(6):269-74.

41. Blom EH, Duncan LG, Ho TC, Connolly CG, LeWinn KZ, Chesney M, et al. The development of an RDoC-based treatment program for adolescent depression: "Training for Awareness, Resilience, and Action" (TARA). Frontiers in Human Neuroscience. 2014;8.

42. Graneheim UH, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: A discussion paper. Nurse Education Today. 2017;56:29-34.

43. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qual Health Res. 2016 Nov;26(13):1753-1760. doi: 10.1177/1049732315617444. Epub 2016 Jul 10. PMID: 26613970.

44. Kajanoja J, Valtonen J. A Descriptive Diagnosis or a Causal Explanation? Accuracy of Depictions of Depression on Authoritative Health Organization Websites. Psychopathology. 2024 Jun 12:1-10. doi: 10.1159/000538458. Epub ahead of print. PMID: 38865990.

45. Nock MK, Ferriter C. Parent management of attendance and adherence in child and adolescent therapy: a conceptual and empirical review. Clin Child Fam Psychol Rev. 2005;8(2):149-66.