Article

The Experience of Depression: A Qualitative Study of Adolescents With Depression Entering Psychotherapy

Global Qualitative Nursing Research
Volume 3: 1–12

DOI: 10.1177/2333393616649548
gqn.sagepub.com
SAGE

Katharina Weitkamp[1], Eva Klein[1], and Nick Midgley[2]

Abstract

There is a lack of research in health psychology on the subjective experience of adolescents with mental health disorders. The aim of this study was to explore the experience of depression and the journey into therapy of young people (YP) diagnosed with depression. Semi-structured interviews were carried out with six YP (5 female, aged 15–19). Interviews were analyzed using Interpretative Phenomenological Analysis. The following four key themes were identified: "Suffering is experienced as overwhelming," "An experience of loneliness and isolation," "Struggling to understand the suffering," and "Therapy as a last resort." Reasons for a delay in accessing treatment were not knowing what is "normal," the feeling that they have to deal with it by themselves, and/or the lack of a caring adult who supports the YP in getting help. The findings suggest the ongoing importance of reducing stigma and promoting mental health education for YP as well as parents, school staff, and health professionals.

Keywords

adolescence, depression, experience, psychotherapy, health seeking, Interpretative Phenomenological Analysis

Received April 12, 2016; accepted April 19, 2016

Introduction

More than a decade ago, the World Health Organization identified a severe service gap for mental health difficulties, particularly in childhood and adolescence (World Health Organization, 2003). Although different countries have made an effort to tackle this, such as the United Kingdom's Improving Access to Psychological Therapies program (IAPT), the service gap has remained largely unchanged in many countries (Wittchen et al., 2011). In Germany, there is still a large gap in mental health care provision for adults and children alike. Depressive symptoms are widely prevalent in young people (YP; Bettge et al., 2008). About 5.6% of adolescents between 13 and 18 years meet diagnostic criteria for a depressive disorder (Costello, Erkanli, & Angold, 2006), rendering affective disorders of particular relevance for mental health services. Treatment rates are very low in YP, with less than half of children and adolescents with identified mental health problems receiving any kind of treatment (Ravens-Sieberer et al., 2008; World Health Organization, 2003). Moreover, the delay in getting professional treatment is a major issue, with many children and adolescents only accessing help a number of years after the onset of the mental health condition and considerably later than adults (Korczak & Goldstein, 2015; McGorry, Purcell, Goldstone, & Amminger, 2011).

These findings might be due to a number of reasons, including fear of stigmatization, as well as to difficulties in identifying depression in adolescence. Most cases of adolescent depression go undetected (Kessler, Avenevoli, & Merikangas, 2001). This may be due to a difficulty in differentiating warning signs of depression from outdated but persisting views of "normal" teenage behaviors. Rutter (1980), for instance, established that most adolescents' lives were not characterized by the "storm and stress" that some earlier theorists had assumed; yet, this view is still persistent in folk psychology. In addition, diagnostic criteria for depression in the *International Classification of Diseases* (ICD-10; World Health Organization, 2010) and the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) were primarily formulated based on adult criteria. Although the core symptoms of a major depressive episode might be the same for adolescents and adults, there seem to be other aspects that

[1]MSH Medical School Hamburg, Germany
[2]Anna Freud Centre and Research Department of Clinical, Educational and Health Psychology, UCL, London, United Kingdom

Corresponding Author:
Katharina Weitkamp, MSH Medical School Hamburg, Am Kaiserkai 1, 20457 Hamburg, Germany.
Email: Katharina.weitkamp@medicalschool-hamburg.de

differ. For instance, irritability has been identified as an additional characteristic of adolescent depression alongside low mood in the *DSM-5* (APA, 2013).

Despite this amendment to the existing diagnostic criteria, it is not clear whether there are more significant differences in the expression of depression in YP that we are still missing, particularly in view of the low-detection rate of adolescent depression. Both the manifestations and the prominence of symptoms may differ between adolescents and adults, as the experience and needs of YP might be different to adults due to their unique emotional and cognitive functioning.

To improve our understanding, some research has been undertaken in which YP themselves are asked about their experience of depression. In a questionnaire study involving adolescents with depression in New Zealand, the researchers identified the aforementioned irritability as the most common characteristic alongside interpersonal problems and thought-processing symptoms (Crowe, Ward, Dunnachie, & Roberts, 2006). Diminished ability to concentrate or think is a diagnostic criterion in the *DSM-5*; however, interpersonal problems are not covered (APA, 2013). A strength of this study was to listen to the YP's voices; however, they relied only on standardized measures (Crowe et al., 2006; Lachal et al., 2012), thus potentially limiting the validity, as the YP were only able to report what was asked in the questionnaire. In this sense, interview studies seem more appropriate to allow for new themes to emerge from young service users' accounts of their experience (Farmer, 2002). To date, there are only a limited number of studies focusing on the YP's experience of depression. Dundon (2006) reviewed the current state of research in her meta-synthesis and was able to include six qualitative studies of depressed and non-depressed adolescents. All studies were carried out in North America with two more recent additions from Australia (McCann, Lubman, & Clark, 2012) and the United Kingdom (Midgley et al., 2015). Common across the YP's accounts in the different studies was the struggle to make sense of the situation, social withdrawal, trying to deal with the situation by self-harming, suicidal ideation, and attempts to and/or engaging in risky behavior. School problems were also very prevalent in previous studies (Dundon, 2006; Farmer, 2002), and the authors of these studies frequently commented on the severity of the symptoms described by YP.

In a recent study by Midgley and colleagues (2015), a British sample of 77 adolescents (11–17 years) who had been diagnosed with depression and were entering outpatient psychotherapy, were interviewed about the individual experience of depression as part of a large randomized controlled trial, the Improving Mood With Psychoanalytic and Cognitive Therapies study (IMPACT; Goodyer et al., 2011). Five themes were identified in this study: *misery, despair, and tears; anger and violence toward self and others; a bleak view of everything; isolation and cutting off from the world*; and *the impact on education*. The authors concluded that anger and a sense of isolation may be important warning signs, which should receive greater attention if detection levels for adolescent depression are to be improved (Midgley et al., 2015).

Farmer (2002) interviewed five YP with depression (13–17 years) in the United States and identified that anger, fatigue, and interpersonal difficulties were focused on by the YP. Participants did not directly discuss sadness, crying, or pessimism, which are the core features of depression in a psychiatric diagnosis. Farmer has stressed that for a richer understanding of the experience of adolescent depression, it is important to take into account contextual factors as well as the more typical symptoms stated in the ICD-10 (World Health Organization, 2010) and *DSM-5* (APA, 2013). She argues that these contextual factors, such as the family environment or difficult relationships with peers, have not received enough attention.

It remains to be seen whether these experiences of contextual factors, anger, and irritability; the desire to make sense of the situation; and social isolation are transferable to the experience of adolescents in Germany, and it is unclear how these experiences may affect the way that depressed adolescents seek therapy. German mental health care for children and adolescents is primarily delivered by registered psychotherapists and psychiatrists in private practices for outpatient treatment and specialized psychiatry wards in hospitals for inpatient treatment. Costs for psychotherapy are covered by statutory health insurances. The number of registered child and adolescent therapists is regulated (and limited) by the National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung [KBV]). Unlike the situation in the United States or the United Kingdom, about half of German youth psychotherapists have a psychoanalytic training background (47.8%; Bundesregister der Kassenärztlichen Bundesvereinigung, 2011). Families usually need to initiate contact with a therapist themselves and be proactive in getting professional help. Often, there are waiting times of about a couple of months for outpatient treatment.

The aim of this study was to build on previous studies, by examining the lived experience of YP diagnosed with depression living in Germany, and additionally to look at the way these YP accessed therapy in the context of the German mental health system, including reported reasons for any treatment delay.

Method

The current study is a small-scale, exploratory study, in which we carried out semi-structured interviews with six adolescents with depression entering outpatient psychotherapy in Germany. In addition to the experience of depression, we studied the expectations of therapy that will be published elsewhere (Weitkamp, Klein, Wiegand-Grefe, & Midgley, submitted). The study was conducted in cooperation with psychodynamic therapists working in their own private

practice in and around Hamburg, Germany, as well as the outpatient treatment facilities at the Michael-Balint-Institut, Hamburg, which is a training centre for psychodynamic therapy offering outpatient treatment. The YP were all entering psychodynamic therapy, although only one of the YP seemed to have an understanding of different therapy approaches and wanted psychodynamic treatment specifically. Eligible patients, referred between September and December 2014 were approached by their therapist for participation after the first session. The adolescents as well as their parents (if the young person was below the age of 18 years) received written information about the study. Thirteen YP were approached for participation, and six of them (and where necessary, their legal guardian) gave their written informed consent to participate in the study. The Ethical Board of the Hamburg Chamber of Psychotherapists approved of the study (16/2014-PTK-HH).

Inclusion criteria were youth (aged 14–19 years) entering psychotherapy after undergoing a maximum of two sessions with a therapist, currently suffering from a depressive disorder, and having sufficient command of the German language. Exclusion criteria were pathology or a cognitive impairment too severe to participate, as rated by therapist or interviewer appraisal. The therapist made a clinical judgment about whether it was appropriate to invite the young person to take part in the study. Possible reasons for not inviting the YP were, for example, because they were in a state of crisis or because their mental health felt too precarious at this point to ask them to participate in research interviews. Prior treatment was not an exclusion criterion, because we were interested in the experiences of adolescents seeking help in a naturalistic context.

Participants

Six YP entering psychotherapy participated in this study. They were between 15 and 19 years old, and five of them were female. They all met the ICD-10 diagnostic criteria for mild to moderate depressive episodes. Each showed comorbid symptoms of another disorder as well. Four fulfilled criteria for a comorbid posttraumatic stress disorder and the other two for a comorbid anxiety disorder. They all shared experiences of difficult life situations ranging from loss of close ones, parental divorce, parental psychiatric disorders, to sexual or physical abuse. Furthermore, the majority of the YP had been suffering from depression for a couple of years already before entering psychotherapy.

Data Collection

The interviews were carried out by the first author (K.W.), using a semi-structured interview schedule called the *Expectations of Therapy Interview* schedule (available from the author Nick Midgley). The interview schedule covers (a) the individual's experience of their depression and the effects on their daily lives, (b) how they understand their difficulties, (c) their path to seeking treatment, and (d) expectations and hopes for what will happen in therapy. The interview deliberately encourages the YP to describe their experiences in their own words. Open-ended example questions might be, "Can you tell me how you came to be referred to psychotherapy?" or "In what way do these things affect your life?" This guideline was translated into German and then retranslated back into English by a professional translator and native speaker. An experienced qualitative researcher (Silvia Krumm) gave feedback on the first interview to ensure the quality of the in-depth nature of the interviews. The interviews aimed to elicit an in-depth narrative of the subjective experience of each participant. The schedule was used only to indicate the general area of interest and offered prompts for eliciting a rich account, rather than structuring the interview according to any pre-determined concept of depression (Smith & Osborn, 2007).

The interviews were carried out at the Medical School Hamburg. At the start of the interview, participants were asked again for their consent to audiotape and were reminded that they had the right to withdraw from the interview at any time and that questions did not have to be answered. The complete interview took about 1.5 hours and consisted of two parts: first, the *Expectations of Therapy Interview*, and second, a semi-structured diagnostic interview, the *Kiddie–Schedule for Affective Disorders and Schizophrenia* (K-SADS; Delmo, Weiffenbach, Gabriel, Stadler, & Poustka, 2001; Kaufman et al., 1997). The purpose of the second interview was to provide a diagnostic assessment and confirm the presence of a depressive disorder; but this data were not used in the qualitative analysis reported below. In addition, use of medication and suicidal ideation were assessed. Participants received €20 as compensation.

The interviews were professionally transcribed verbatim, omitting any potentially identifying data such as names, professions, or places. Participants were able to choose a pseudonym. In cases where they did not choose their own pseudonym, participants were assigned a pseudonym.

Data Analysis

For data analysis, we used Interpretative Phenomenological Analysis (IPA) developed by Smith, Flowers, and Osborn (1997). IPA is an appropriate approach when the aim is to explore how people make sense of specific experiences; it allows for a focus on the lived experiences of the individual. Furthermore, IPA is an inductive approach, which allows for topics to emerge from the data that were not anticipated by the researchers. Although staying close to the experience of the participants, IPA recognizes that a "double hermeneutic" is at play within the analysis of any phenomenon: "The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2007, p. 53).

Because IPA emphasizes the importance of an in-depth understanding of an individual's experience, it is mostly used with small homogeneous sample sizes; the authors recommend a sample size of four to eight as appropriate for an IPA study (Smith, Flowers, & Larkin, 2009).

There are certain steps that guide IPA (Smith & Osborn, 2007). First, following an idiographic approach, the analysts begin by looking in detail at the transcript of one interview before moving to the others. This first step includes careful reading of the transcript and commenting on what seems interesting or significant not only in relation to the general research question but also in terms of use of language or the sense of the person themselves that comes across. The research questions guided our analyses. In this sense, we were particularly looking for data where the YP spoke about their experience of depression, the impact that depression might have on their lives, and their journey into therapy—but we did not in any way pre-determine that themes might emerge in relation to these research questions. In the next step, from the comments and notes on the first transcript, emerging themes are formulated. These themes are grounded in the particularity of the interview (e.g., Melissa: "Expected negative reaction of friends"). The next step involves an analytical ordering of the themes as a way of clustering them. These clusters are given a name and represent superordinate themes. A superordinate theme was, for instance, "fear of stigmatization," which incorporated the theme from Melissa mentioned above, but included also Melissa's subordinate theme of "playing a role" or "hiding her suffering." These steps are carried out for each of the transcripts separately. Finally, these superordinate themes form the basis for the cross-case analysis where researchers identify higher level themes across all the cases (e.g., the cross-case theme "experience of loneliness and isolation" might integrate the superordinate theme "fear of stigmatization" from Melissa, as well as the theme "loneliness is the worst thing" from the analysis of Shadow's interview).

Data analysis was carried out by the first author (K.W.) and E.K. and audited by N.M., who took on a supervisory role. For each interview, K.W. and E.K. carried out the first steps of IPA, the case analyses, and the developing of emerging themes separately. We discussed these emerging themes with a focus on the interviewee's account to ensure that the analysis was grounded in the data. In the case of only one researcher marking a part of the interview as important and coding an emerging theme, we included these in our initial stages of analysis to enhance richness of emerging themes. Generally, there was agreement on the meaningful parts of the interviews in relation to the research question, with similarly phrased emerging themes between the two researchers. At the level of emerging themes, each researcher kept their own phrasings of the themes and created superordinate themes independently based on these themes individually for each case. In the next stage, the cross-case analysis, the superordinate themes of both, K.W. and E.K., were combined and formed the basis of the search for cross-case themes. This step was again carried out first separately and then discussed to reach conclusion. Each step of the qualitative analysis process was independently audited by N.M. as suggested (Smith et al., 2009). This included cross-checking between the superordinate themes and the transcript, to ensure that the data interpretation was grounded in the data, and also a discussion of each superordinate theme, to ensure that they were not merely descriptive, but offered a meaningful interpretation of the data in the light of the research questions and the participants' experiences. One of the interviews and the superordinate themes of all cases were translated into English in full, to enable close supervision by N.M.

Results

The analysis of the interview data led to four main themes. The individual narratives were unique but with recurrent aspects across the YP's experiences. The following four interrelated themes came up in each of the participants' interviews: "Suffering is experienced as overwhelming," "An experience of loneliness and isolation," "Struggling to understand the suffering," and "Therapy as a last resort." In preparing the manuscript for publication, the original quotes were translated into English. Pauses and hesitations in the quotes are shown as full stops in brackets. One full stop is the equivalent of one second.

"That's Just So Hard"—Suffering Is Experienced as Overwhelming

In this theme, the YP spoke about the experience of being overwhelmed by the symptoms as well as the consequences. At the time of the interviews, the YP all spoke of the core symptoms of depression as described in the psychiatric literature, including depressed mood, loss of interest, fatigue, trouble concentrating, sleeping problems, and so on, but throughout their narratives, a strong sense of suffering and burden was prevalent. This high level of suffering became clear through their frequent usage of words like "completely" or "extreme." For example, Melissa described having "extreme problems concentrating," before she went on to describe her current problems.

> Suicidal thoughts, self-harm, just this completely negative attitude in general. Just self-hatred, all that kind of stuff.

A sense of resignation and passivity toward the overwhelming and complex difficulties could be felt in all the interviews. Samantha, for example, described herself as being in a "black hole" since a traumatic incident a couple of years earlier. Katrin, who had already been suffering from depressive symptoms for a couple of years, summarized her situation as, "I have been living in chaos for a while now." Both metaphors, the black hole and the chaos, illustrate the sense

of a loss of control over one's life and the feeling that there is no way out of their situation. Lara, who was grieving the loss of a parent and dealing with the abuse of a family member, felt "destroyed."

In all the interviews, the YP also spoke about irritability and aggression. The accounts differ, however, in the way that the aggression is experienced, such as being rather diffuse or having a clear object (the YP themselves or close ones), as in the case of Lara who felt strong anger toward the abusive family member:

> Intense aggression . . . has always been there.

Whereas for Melissa, the aggression seemed to come out of nowhere:

> And also often, that I simply (.) without any reason get in a bad mood or I am totally annoyed.

In the interview with Katrin, a sense of aggressive self-hatred was visible, coupled with almost an absence of aggression toward others. Adding to the burden of psychological symptoms, several of the participants also talked about physiological symptoms, in particular insomnia:

> I could not sleep at all, just zero. (Shadow)

The intensity of sleeping problems led on to another aspect of the impact that the psychological distress had on the YPs' life, the impact on education:

> Erm, difficulties sleeping (..) well, I am often sad, (.) I, um, miss out on school frequently, because, um, I have headaches (.) or just, well, I have to cry a lot, because, well, I am very burdened emotionally. (Anna)

The impact on education was seen in all the YP, ranging from dropping out of school for a period of time, repeating a grade, to a significant drop in performance at school. For Shadow, this loss in performance had only been transient:

> Well, um, in school I completely deteriorated um in that period of time . . . fortunately that was not long, but it was maybe a month, one and a half months, that was just immediately after it, because it was very acute then and because I, really, I could not concentrate. It was not only school, also football, I did not show any performance.

In addition, the degree of the experienced distress was visible in the impact it had on social relationships. Most of the YP talked about the reduction of their circle of friends. The dynamics behind this were not clear in most cases, but for Melissa, it seemed to be an active process in an attempt to take care of herself:

> But it came from me, that I . . . broke off contacts with a lot of people, simply because it was just too much for me.

Although the YP often described the loss of friends, they were able to keep up some close friendships that seemed to counterbalance the overwhelming experience to a certain degree. In the narratives, there was not so much a sense of grief over the loss, but rather gratefulness and knowing whom you can really count on. Shadow expressed this gratefulness a couple of times:

> Well, all this time I have three, four friends, well actually they are female friends, who I can count on, and I am proud of them, well, that they are my friends.

"Loneliness Is the Worst Thing for Me"—Experience of Loneliness and Isolation

A second theme that is strongly related to the overwhelming nature of the feelings is the experience of loneliness and isolation, which was described by all the participants in the study. There are several important aspects to the experience of loneliness: difficult emotions will come to the surface; feeling lonely, because the YP keeps the burden to themselves as a protection against potential stigma; keeping to themselves to protect others from suffering; or feeling isolated because of a lack of language for expressing the difficult experiences. The different aspects will be discussed in turn.

The interviews conveyed a sense of fear of being alone; a fear of being left to fight the overwhelming emotions all by themselves. One may speculate that the YP feel that the loneliness makes them feel vulnerable, like being faced by an enemy who is about to strike when you are on your own. Samantha expressed this surfacing of the suppressed difficult emotions:

> Well, if I am alone, I just go crazy in a way.

Particularly Shadow, as the only male YP in the study, seemed to struggle with disclosing his feelings to anyone. This was noticeable throughout the interview, in the sense that he did not seem to have the words to express his situation, on one hand; at the same time, he appeared to be trying to adhere to a male role of being strong and self-sufficient, which was visible in the way that he downplayed his obviously difficult situation. Shadow clearly had the wish to disclose to someone, which he expressed in a wish for some kind of group therapy to meet people where he could actually speak about his problems:

> And maybe, that you can talk about it in a group that you can say: "I am [Shadow], I have this and that problem. What do you think, what is your impression, what is your problem?" . . . Because I can't possibly walk into my classroom and say: "you know what happened to me?" Well, I could, but . . .

On a more interpretative level, two somewhat different aspects of the experience of loneliness seemed to emerge in the sample. For three of the YP, a caring parent was missing

or the YP described how their parents seemed not to be fulfilling their parenting roles, partly due to their own mental health problems, partly due to estrangement as a result of the parents' separation. For these YP without the experience of a caring parent, loneliness and isolation arose from this feeling of being left on one's own. Below, we see how for Anna, this loneliness was perceived as a pressure to be left to fend for herself to secure a successful future:

> Well, somehow I feel a rather great pressure on me, because um I am in the last year of school and um I would like to get a very good Abitur [A-level or high school diploma], (.) because I (.) don't have anyone, well, that I can count on really.

The other three YP spoke of having at least one caring parent, and in these cases, the sense of isolation and feeling alone with the difficulties was partly due to the YP not wanting to burden close ones:

> Well, I just did not want to tell [my parents] because I did not want them to worry or to feel guilty or something like that. (Melissa)

Almost like a vicious cycle, these YP were aware of the distress that they might cause their parents and wanted to protect them from it, by not speaking about what was going on for them. Shadow added to this way of thinking in describing how he felt, when his father almost forced him to talk about what was really going on when he accidentally found him lying awake one night:

> He had never, never expected that from me. Because, to some extent I was able to hide it well from him. At home I just said: "It's okay, fine, I am fine." (.) But that was just painful for me seeing him like that, the way he is suffering, because he really suffered from it—that I was in such a bad state. And that of course was again a little, well, more negative.

Isolation was further expressed by indirect accounts of a fear of stigmatization that "you, you just can't talk about it," as Shadow put it. Melissa, for instance, tried to protect herself from assumed negative consequences by keeping her distress to herself:

> For that reason I could not show it to anyone, because I never talked to my friends about (.) well (.) my feelings. Well, at least not about the negative ones. And that is why I always had it accumulate inside of me until (.) the evening. (.) And well, then it all came out at night.

However, there seemed to be an understanding among our participants that there might be different kinds of mental health problems with differing levels of negative stigma attached to them. Anna, who was grieving the loss of a parent and was grappling with an incident of abuse, seemed to implicitly make a distinction between these two experiences. Bereavement seemed to be a more acceptable form of mental health problem, because it just happened to her without her own agency. Experience of abuse, however, seemed to be stigmatized. The two quotes from Anna below illustrate this distinction:

> I am not like ashamed of my problems. Because this is not really my fault. . . .

> I, um, am not like hiding it, that I am in therapy, only just that I live at [a friend's house], because it needs to stay a secret, my address and such. (.) Well, and I don't really want that (.) they would draw any conclusions from it, what happened in the relationship with my ex-boyfriend.

To add to the complexity of the experience of isolation, for Melissa, in particular, the lack of understanding of others was distressing. Because she kept her difficulties to herself, her parents and her teachers could not understand her behavior and lack of performance at school. Being seen by them as lazy was painful for her, but did not lead to the disclosure of her difficulties.

> Then, by and by I just got totally bad grades, because I just could not tell anyone that I am not handling it, because I just can't and not because I don't fancy doing it.

"I Only Know That I, Well, Suffer Constantly, But Why, I Don't Know"—Struggling to Understand the Suffering

A third theme, which was pervasive in the YPs' accounts, was the notion of not being able to understand what they were going through. This "not knowing" seemed to be experienced as distressing as the symptoms. Melissa expressed this in the following words with a frequent use of interrogatives, which captured her helplessness and the burden of not understanding where her problems had come from:

> That I do not know at all, where all this comes from, why is that, why do I have this bad mood all the time and (.) in general, where does all this come from. And I would just like to know the answers to that. Well, I would like to know, (.) how this has happened. (.) And where did this begin and so on.

Some of the YP hinted at their own ideas about why things had become difficult. However, these seemed to be independent of and rather co-existing with the strong feeling of not knowing and not understanding. For Melissa and Katrin, the overwhelming emotions felt like a blockage or a dam:

> Everything in my head is blocked. Because the more pain you suffer, the more your brain gets blocked. (Katrin)

Lara, however, seemed to have a better understanding of her depression, as she felt that something within her had been

destroyed by the traumatic experiences she had experienced. She spoke of how the emotional numbing was due to a split that had taken place:

> My feelings are happening rather in my head and this connection between the head and, um, the soul is actually not fully there anymore. And there are just only very, very, very isolated things that find the way.

Still, these explanations were not sufficient for Lara and the others to take away the pervasive feeling of not fully understanding why they were depressed. This might be illustrated by Melissa and Katrin who both had prior therapy experience in which parental divorce was discussed as a causal factor in their depression by the therapist; however, Melissa and Katrin both shared the experience that the divorce of their parents was not sufficient to explain their degree of suffering. We see this in the interview with Katrin. In her answer to a question about her explanation for why things came to be like this, she distanced herself from the explanations of others. To her, the estranged relationship with her father did not suffice to explain her current suffering. Rather, the loss of close ones seemed more relevant for her:

> No. That's it really, nobody knows [why]. (.) Well, most people say like, that it is probably because of my father who more or less turned away from me and did not want me anymore. Yes, that would have hurt me by all means back then but by now I can live with that quite well because he apologized to me. . . . Well, erm, (.) yes, maybe as well, because I have lost so many people.

Another point related to the struggle of understanding is the sense that some YP almost seemed astonished about the change of their personality, particularly visible in Shadow's account of his life after a traumatic incident. In the quote, Shadow shows how he grappled with this change, which he would not have thought possible before:

> I did not notice it at all. I was literally just sitting on the chair and sometimes I did not take part in the conversation or did not even listen, I was just not there at all. Even when you talked to me directly, I did not notice.

Later on in the interview, he also emphasizes that his father could not get his head around his son's situation, possibly mirroring his own struggle: ". . . he would have never, never have expected that from me."

"I Don't Need That"—Therapy as a Last Resort

In this theme, we capture the reluctance to seek professional help, as well as individual coping attempts. For all the YP in this study, there was a significant time-lag between them first experiencing depression and then seeking professional help, although the reasons for this varied. For Lara, this was due to a discouraging parent, whereas for Anna, it was difficult to find a therapist. She called up a number of therapists who only put her on waiting lists and did not give her an initial appointment. Only with the help of a liaison teacher at her school did she get an initial appointment with a therapist. For the other YP in this study, treatment delay seemed to be partly due to the notion that things have to be really bad before you seek help. The tipping points were, for instance, additional traumatic experiences or an increasingly unbearable level of symptom severity.

For the YP in this study, it seemed important to try to be autonomous, and to show that they were able to deal with the difficulties on their own. All of them spoke about living with depression for a long time before they sought professional help. Therapy was perceived as a last resort that you only turn to when things are really bad, as if getting help from others would be perceived as a deficit, a sign of weakness. Samantha talked about her mother and her siblings urging her to seek therapeutic help, which she refused to do up until a certain point in her life, while more and more difficulties were mounting up:

> But I have never seen it for myself: "I have to do this now," well, I wasn't ready, I said: "I am fine. Other people have worse problems than me." but at a certain moment one does not manage by oneself any more.

In terms of the different ways that the YP tried to manage their difficulties, Lara gave the impression of being a very independent young woman who had learned to deal with problems herself from a very young age. She proved to be very resilient against all the difficulties that she faced in her young life, like the death of a parent and experiences of abuse, which didn't stop her from starting therapy again at a later point in life. The following quote illustrates how Lara had found some of her own ways to manage difficult feelings:

> Partially, I also try to solve this anger and this aggression through reading, because I, erm, well, this calms me down a little.

Another means to try and keep distress at bay, used by most of the YP in this study, was the distraction of being with friends. In most of the interviews, there was a clear sense that friends were a valuable resource in that their friends served as an escape, even if the YP might not disclose their difficulties to them. Anna, who was very burdened by the lack of parental support and had the feeling of being left alone in the world, expressed this laughingly:

> That I, (..) that I am happy when I can do stuff with my friends. That is like being on holiday.

Meeting friends had similar connotations for Samantha:

> But when I am out with my friends, everything is forgotten. In those moments, all is well.

Interestingly, another way of trying to cope with the overwhelming feelings was active pushing away of difficult thoughts and feelings. Katrin described this with a metaphor:

> I am a world champion in suppression.

The image of the world champion is a powerful indicator of how Katrin experienced the process of fighting against the distressing symptoms of depression. A world champion surely puts a lot of time, effort, and practice into developing this specific skill. Furthermore, suppression was discussed in two ways: first, as a way of managing feelings, as mentioned above, and second, as a goal of therapy. Shadow talked about this in relation to his expectations of what therapy could help him achieve. To him, it was clear that forgetting the traumatic experience was not an option, but in the absence of another idea about how to deal with his suffering, he hoped for suppression:

> And, if I can forget in a way what happened. Well, maybe not really forget, but let's say suppress it a little bit (.)

Relating back to the overwhelming burden of the psychological difficulties put on the YP, Melissa gave a moving account of the huge effort that she was facing in trying to deal with the difficulties by herself. For her, also, the suppression of feelings seemed to be an approach to managing, if not solving her problems:

> And (.) well, if I was in a bad mood, then (.) I always suppressed it the whole time. (.) And nobody ever noticed it. But this was just extremely arduous for me.

As Melissa made clear, the different attempts at suppression and distraction were not leading to a sufficient reduction of symptoms or alleviation of the distress for most of the YP. We could sense from the interviews that this in itself was again perceived as another failure and could add to their distress and possibly a sense of self-blame. As Samantha revealed with a sense of resignation,

> Well, it is just annoying for me, because I try it and I don't manage.

The notion of trying to deal with it by themselves was closely linked to the theme of therapy as a last resort. It seemed that psychotherapy or seeking professional help was only seen as acceptable when things were genuinely very severe. Thus, for Anna and Lara, who both shared the difficult situation of losing one parent and falling out with the other, this hesitation toward therapy did not come up. For them, it seemed acceptable to seek help, and indeed, they had longed for therapy for a period of time before they managed to get a therapist. This is illustrated by Anna's account of her journey into therapy.

> Well, I was always searching for a long time, because for a long time I had the need, um, so to say, to start therapy.

Linked to this idea of therapy as a last resort and the long journey to seek help was, for some of the YP, the question of what is within the range of "normal" adolescent experiences of sadness or irritability. Melissa, who struggled with a lot of irritability in her day-to-day life, only began to understand that her experience had not been "normal" when looking back:

> Well, I just did not really realise it or take it seriously. I just thought, that from time to time I am in a bad mood or that I am more irritable than others, but I have never really thought, that I might really have some kind of illness. And that just got worse and worse. . . . well, I just perceived it as normal. But now, in hindsight, I realize that this wasn't normal at all.

One reason why several of the YP seemed not to seek help sooner was because their self-esteem was very low, so they felt that they were not worth the help and care of others. The following statement by Katrin illustrates how this low self-esteem and lack of caring for herself was compounded with resignation and passivity:

> Actually, I am, I let far too much just happen to me. . . . Um, probably because I don't really care about me.

Shadow experienced the prospect of therapy and finally getting help as a sign that he might be worth being cared for:

> And also, well, ehm, that someone is taking care of me, that is helping me in a way, in that I say, well maybe I am important after all, that I say, someone will take care of me and will help me.

Discussion

This study aimed to investigate the experience of depression in a German sample of YP. Four interlinked themes were identified that came up in each of the participants' interviews and will be discussed in turn: "Suffering is experienced as overwhelming," "An experience of loneliness and isolation," "Struggling to understand the suffering," and "Therapy as a last resort."

First, the YP touched on the core symptoms of depression as described in the ICD-10 (World Health Organization, 2010) and *DSM-5* (APA, 2013). In this sense, the experience of the YP reflected the diagnostic criteria for adult depression. This is in line with findings in previous qualitative studies on the experience of YP with depression (Lachal et al., 2012; Midgley et al., 2015). However, one of the core symptoms of depression in the diagnostic systems, "change in appetite and weight gain/loss," was not discussed by the YP in our study, or in previous studies (Lachal et al., 2012; Midgley et al., 2015), suggesting that

this may not be a core symptom that YP associate with their experience of depression.

The YP also spoke about ongoing and strong feelings of aggression and irritability, which seem to be quite common for adolescent depression (Crowe et al., 2006; Farmer, 2002; Lachal et al., 2012; Midgley et al., 2015). Irritability is recognized as a diagnostic criterion in the *DSM-5* (APA, 2013). However, the current sample showed high comorbidity with posttraumatic stress disorder, in which irritability is a core symptom as well. We cannot conclude whether YP without comorbidity would have reported the same level of irritability, but certainly the YP themselves did not distinguish between symptoms that they felt were posttraumatic as opposed to part of their depression. Furthermore, sleeping problems, difficulties concentrating, and, related to this, the negative impact on education were common in our sample, as has been found in other interview studies (Crowe et al., 2006; Farmer, 2002; Lachal et al., 2012; Midgley et al., 2015).

A dominant experience of the YP was the "overwhelming" nature of their reported symptoms and distress. This feeling of being overwhelmed might be considered an overarching theme, with the different themes all contributing to this overall sense of distress, including the struggle to make sense of the situation, the feelings of isolation, as well as the subjective pressure to deal with "it" by yourself. This pervading sense of suffering has already been reported in other samples of YP with depression (Lachal et al., 2012; Midgley et al., 2015). The recurrent nature of this finding emphasizes how much YP feel unable to cope when experiencing clinical levels of depression and the importance of reaching this vulnerable group and offering targeted care.

All the YP talked about their struggle to understand the suffering that they were experiencing. The accounts were accompanied by strong feelings of helplessness and a lack of control, as if the YP were paralyzed by the "chaos" that they were facing. In an Australian study, this "struggle to make sense of their situation" (McCann et al., 2012, p. 334) was a central theme as well. In their meta-synthesis of previous qualitative studies, Dundon (2006) summarized this experience as, "Teens expressed confusion in having these symptoms, realizing they are different than their peers, and not knowing why" (p. 389). This echoes the findings of our study, although it may not convey the sense of distress that accompanied this feeling of confusion among the YP in our study. This may suggest that better education about depression, as well as the aims, processes, and benefits of treatment, might help reduce the perceived barriers to entering treatment and help more YP in their struggle to make sense of what they are experiencing.

Although not an explicit aim of the study, the YP mentioned a number of potential triggers for depression, namely, interactional difficulties, like parental abuse, parental mental health difficulties and/or suicidality, and loss of a parent or a loved one through death. Although some of these experiences could be seen as triggers for posttraumatic stress, none of the YP spoke of them in that way. Interestingly, the YP were all from single parent families, with the parents either being divorced or a parent had died. Clearly, this is not true for all YP experiencing depression. However, in the study by Farmer (2002), the YP all came from divorced families as well, although sample selection was not based on parental marital status in either of the two studies. Farmer also stressed the lack of power that the YP have at their developmental level to shape their interpersonal lives. This played a role in the current sample as well, being faced with difficult situations at home. However, some of the YP had already managed to care for themselves by leaving a distressing situation at their parental home, ending abusive relationships, or initiating therapy on their own accord.

The feelings of loneliness and isolation, the third theme, were very pervasive in the interviews and central to the experience of suffering for the YP. Similar aspects of isolation were also reported in Dundon's meta-synthesis, like feeling different and not wanting to burden others (Dundon, 2006). Social withdrawal was described by YP in other interview studies as a distressing factor (Lachal et al., 2012; McCann et al., 2012; Midgley et al., 2015), as it has been in a study with young adults with social anxiety (Hjeltnes, Moltu, Schanche, & Binder, 2015). In our sample, the YP, while withdrawing to some degree, were able to maintain some of their friendships and saw their friends as a source for distraction and "holiday" from their difficulties. However, the YP felt unable to confide in these friends and share their distress with anyone, for fear of being stigmatized or judged. This in turn added to the sense of loneliness and isolation. The aspect that disclosure to friends can be difficult was also mirrored in the meta-synthesis by Dundon (2006) and suggests that the detection of depression in YP will continue to require adults (both parents and others, such as teachers) to be alert and sensitive to the signs of depression, as YP may not always feel able to disclose their difficulties to peers.

The YP in our sample seemed to share a belief that they had to deal with their difficulties by themselves, possibly due to a mixture of high demands toward themselves, feelings of shame, and fear of stigma. Not being able to cope led to feelings of incompetence and self-criticism. Therapy was seen as something you turn to only when things are "really bad," such as following the death of a parent. Another aspect of the reluctance to seek help was the lack of knowledge about the degree of emotionality that would be considered "normal" during pubertal transitions. Although at the same time, the YP seemed to be longing for care and help. In the meta-synthesis by Dundon, seeking professional help was also covered. In that review article, YP reported mixed feelings about talking with a professional: anonymity was seen as positive, discouraging was the fear of stigma and stereotyping (Dundon, 2006). This ambivalence was to some degree seen in this study too, and may have severe repercussions for the help-seeking behavior and the potential chronicity of mental

health difficulties. In our study, the YP reported suicidal ideation and self-harming, but only to a limited extent engaging in other risky behaviors, such as sexual promiscuity, drug and/or alcohol abuse, which have had prominence in previous studies (McCann et al., 2012). Whether this was due to the sample or to the YP being hesitant to disclose this information to the interviewer cannot be answered. However, the YP were very open about other similar topics like self-harm and suicidal ideation, suggesting that they were quite honest about their engagement in risky behaviors.

The well-known treatment delay for those with mental health problems in childhood and adolescence (McGorry et al., 2011) is mirrored in our sample. Some of the YP had had years of being untreated and keeping their burden to themselves, while others had a history of entering and dropping out of treatment. Due to the qualitative nature of the current study, it was possible to get some insights into why this treatment delay occurred: In some cases, delay was due to not knowing what is normal, a fear of stigmatization, the view that one should seek help only when it is "really bad," low self-esteem and thus, not feeling important enough to be cared about. In some cases, the delay seemed to be because the YP were trying to find a therapist but were kept on waiting lists for a long time, suffering severely without having any adult support in helping them to get an initial appointment. These futile attempts might be partly due to the German mental health care system where the YP or their caregivers need to proactively approach therapists. With an insufficient number of registered therapists even in larger cities, waiting lists are long. Moreover, if a YP or the caregiver fails to convey a sense of urgency, finding a therapist might be even harder. For Anna, this seemed to be the case. She only got an initial appointment with the help of her liaison teacher and not from her own attempts to contact psychotherapists. Clearly, the German health care system needs to increase the number of registered child and adolescent psychotherapists to seriously tackle the current treatment delay on a structural level. In addition, further efforts to lower the barrier to accessing treatment are necessary for this vulnerable group. For some of the YP in this study, caregivers suggested seeking help over long periods of time, which the YP either refused or gave into, only to drop out of therapy after a short while. Related to this, Bolton Oetzel and Scherer (2003) described adolescents as often not entering therapy on their own account, and rather being at a stage of pre-contemplative reluctance to change according to the transtheoretical model of behavior change (Prochaska & Norcross, 2001). At the point of their interviews, all the YP appeared ready to give therapy (another) try.

Strengths and Limitations

The study reported here is one of the first to focus on the subjective experience of depression in YP and the reasons for treatment delay, particularly in German speaking countries. The YP were recruited from routine outpatient health care in Germany and had the opportunity to identify their own priorities and speak about what they considered to be most significant, which adds to the external validity of the study and warrants to consider what might be learned from these YP.

Nevertheless, it needs to be kept in mind that this study only included those YP who agreed to be interviewed. Thus, we might have missed the more anxious spectrum of depressive patients; although some of the YP reported significant social anxieties in their diagnostic interview. We expected comorbidities as is often the case in routine care in Germany. However, the high rate of traumatization was striking. We cannot be sure whether YP with depression but without further comorbidities would have reported similar experiences, in particular in terms of the high degree of irritability, which is a common symptom in posttraumatic stress disorder. However, because comorbidity is the norm among adolescents suffering from depression (Fonagy et al., 2015), this mixed picture is probably reflective of the reality of mental health difficulties in YP today. Likewise, we did not systematically collect information about previous experiences of therapy or professional help, as YP chose what to disclose as part of the "story" that they were invited to tell in their interview of coming into therapy. Although this allowed the YP to lead the discussion, it limits our ability to report on what levels of professional help the participants in our study had previously received.

We chose a semi-structured interview to collect the data, which required the YP to be able to disclose their personal situation and experiences to an unfamiliar adult. The YP seemed to be able to deal with this unfamiliar situation, and some were surprised about their level of disclosure after the interview. The specific setting of a one-off meeting with a genuinely interested adult seemed to have facilitated the process. However, in some moments during the interviews, it was clear that some of the YP struggled to find a language to express their burdening experiences. Although the interview seemed to be a viable method for this particular developmental level, for future studies, it might be worth considering whether more creative techniques could be incorporated to facilitate access to the YP's experiences on a more non-verbal level as well.

Implications for Practice

The findings lead to the question of whether we should be doing more to educate YP, parents, teachers, and health care providers to detect warning signs of adolescent depression. Based on the themes in this sample, these warning signs, beyond the established diagnostic criteria, might be a sudden drop in school performance, signs of continuous irritability, or interpersonal difficulties at home. To improve detection, screening tools for depression in YP should be developed based on the descriptions of the adolescents themselves, as was recently done by Lachal and colleagues (2012) with the French Adolescent Depression Rating Scale (ADRS).

In terms of the journey into therapy, some YP might have profited from an adult contact person to assist in getting an initial appointment with a therapist in times of long waiting lists. Another important point is that we are still not doing enough to fight mental health stigmatization (Pescosolido et al., 2008). The fear of stigmatization was noticeable in the YP's accounts in relation to social withdrawal and the hesitancy to confide to friends or close relatives. Another finding was the insecurity of the YP about what is normal and at what point the distress may be considered "bad enough" to justify professional help (Savage et al., 2015). Along this line, it seems advisable to promote broader education about mental health at a young age. As part of the Improving Mood with Psychoanalytic and Cognitive Therapies - My Experience (IMPACT-ME) study (Midgley, Ansaldo, & Target, 2014), the research team created a film together with the YP and parents on the experience of depression and therapy that is freely available and may be used for educational purposes ("Facing Shadows" available online at the Anna Freud Centre YouTube channel). Listening to the YP in our study, it would be helpful to have similar educational films in the German language to facilitate an understanding of what is "normal" in terms of mental health and depressive symptoms in particular.

Although there was considerable overlap of the themes about the experience of depression with studies from the United Kingdom, United States, Australia, and France, some of the findings seemed to be quite specific to our sample, such as the low engagement in risky behavior or spending time with friends as a means to escape the difficulties for a while. Likewise, some of the difficulties in accessing therapy seemed specific to the German health care system. Thus, future research could replicate the interviews with another German sample to get a better understanding of whether these aspects were sample specific.

Conclusion

The experience of adolescent depression seems to broadly fit the diagnostic criteria set out in mainstream psychiatry, but with some distinct features. There also seems to be some distinct features in how the YP felt about seeking help for their difficulties that may be specific to this age group. Adding to the knowledge base, in comparison with the current diagnostic criteria for depression, the YP did not report on any issues with change in appetite and/or weight but mentioned high levels of irritability and aggression. Overall, the level of suffering was considerable in this sample. In particular, the YP reported feeling overwhelmed with the situation, struggling to make sense of what was going on for them, feeling isolated, and considering therapy as a last resort, with the notion that you have to deal with the depression yourself.

Acknowledgments

Warm thanks to the young people participating in the study. Special thanks also to Dr. Silvia Krumm and Prof. Silke Wiegand-Grefe for their supervisional advice, and to Helmut Hofmann for his valuable support in recruiting the young people!

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The study was funded by the German Research Foundation (Deutsche Forschungsgemeinschaft, DFG) (WE 5615/1-1).

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bettge, S., Wille, N., Barkmann, C., Schulte-Markwort, M., & Ravens-Sieberer, U., & The BELLA Study Group. (2008). Depressive symptoms of children and adolescents in a German representative sample: Results of the BELLA study. *European Child and Adolescent Psychiatry*, *17*, 71–81. doi:10.1007/s00787-008-1008-x

Bolton Oetzel, K., & Scherer, D. G. (2003). Therapeutic engagement with adolescents in psychotherapy. *Psychotherapy*, *40*, 215–225. doi:10.1037/0033-3204.40.3.215

Bundesregister der Kassenärztlichen Bundesvereinigung [Federal Register of the National Association of Statutory Health Insurance Physicians]. (2011). *Grunddaten 2011 zur vertragsärztlichen Versorgung in Deutschland*. Retrieved from http://www.kbv.de/html/gesundheitsdaten.php

Costello, E. J., Erkanli, A., & Angold, A. (2006). Is there an epidemic of child or adolescent depression? *Journal of Child Psychology and Psychiatry*, *47*, 1263–1271. doi:10.1111/j.1469-7610.2006.01682.x

Crowe, M., Ward, N., Dunnachie, B., & Roberts, M. (2006). Characteristics of adolescent depression. *International Journal of Mental Health Nursing*, *15*, 10–18. doi:10.1111/j.1447-0349.2006.00399.x

Delmo, C., Weiffenbach, O., Gabriel, M., Stadler, C., & Poustka, F. (2001). *Scheduled Assessment of Depression and Schizophrenia, Kiddie-SADS—Present and Lifetime Version (K-SADS-PL)* (5th ed.). Frankfurt a. M: Klinik für Psychiatrie und Psychiatrie des Kindes- und Jugendalters.

Dundon, E. (2006). Adolescent depression: A metasynthesis. *Journal of Pediatric Health Care*, *20*, 384–392. doi:10.1016/j.pedhc.2006.02.210

Farmer, T. J. (2002). The experience of major depression: Adolescents' perspectives. *Issues in Mental Health Nursing*, *23*, 567–585. doi:10.1080/01612840290052776

Fonagy, P., Cottrell, D., Phillips, J., Bevington, D., Glaser, D., & Allison, E. (2015). *What works for whom? A critical review of treatments for children and adolescents*. New York: Guilford Press.

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., . . . Fonagy, P. (2011). Improving Mood With Psychoanalytic and Cognitive Therapies (IMPACT): A pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse

in adolescents with moderate to severe unipolar depression: Study protocol for a randomised controlled trial. *Trials*, *12*, 175. doi:10.1186/1745-6215-12-175

Hjeltnes, A., Moltu, C., Schanche, E., & Binder, P.-E. (2015). What brings you here? Exploring why young adults seek help for social anxiety. *Qualitative Health Research*, 1–16. doi:10.1177/1049732315596151

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., . . . Ryan, N. (1997). Schedule for Affective Disorders and Schizophrenia for School-Age Children Present and Lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*, 980–988. doi:10.1097/00004583-199707000-00021

Kessler, R. C., Avenevoli, S., & Merikangas, K. R. (2001). Mood disorders in children and adolescents: An epidemiologic perspective. *Biological Psychiatry*, *49*, 1002–1014. doi:10.1016/S0006-3223(01)01129-5

Korczak, D. J., & Goldstein, B. I. (2015). Childhood onset major depressive disorder: Course of illness and psychiatric comorbidity in a community sample. *The Journal of Pediatrics*, *155*, 118–123. doi:10.1016/j.jpeds.2009.01.061

Lachal, J., Speranza, M., Schmitt, A., Spodenkiewicz, M., Falissard, B., Moro, M.-R., & Revah-Levy, A. (2012). Depression in adolescence: From qualitative research to measurement. *Adolescent Psychiatry*, *2*, 296–308. doi:10.2174/2210676611202040296

McCann, T. V., Lubman, D. I., & Clark, E. (2012). The experience of young people with depression: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *19*, 334–340. doi:10.1111/j.1365-2850.2011.01783.x

McGorry, P. D., Purcell, R., Goldstone, S., & Amminger, G. P. (2011). Age of onset and timing of treatment for mental and substance use disorders: Implications for preventive intervention strategies and models of care. *Current Opinion in Psychiatry*, *24*, 301–306. doi:10.1097/YCO.0b013e3283477a09

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, *51*, 128–137. doi:10.1037/a0034179

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2015). Beyond a diagnosis: The experience of depression among clinically-referred adolescents. *Journal of Adolescence*, *44*, 269–279. doi:10.1016/j.adolescence.2015.08.007

Pescosolido, B. A., Jensen, P. S., Martin, J. K., Perry, B. L., Olafsdottir, S., & Fettes, D. (2008). Public knowledge and assessment of child mental health problems: Findings from the National Stigma Study-Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*, 339–349. doi:10.1097.chi.0b013e318160e3a0

Prochaska, J. O., & Norcross, J. C. (2001). Stages of change. *Psychotherapy: Theory, Research, Practice, Training*, *38*, 443–448. doi:10.1037//0033-3204.38.4.443

Ravens-Sieberer, U., Wille, N., Erhart, M., Bettge, S., Wittchen, H. U., Rothenberger, A., . . . Doepfner, M. (2008). Prevalence of mental health problems among children and adolescents in Germany: Results of the BELLA study within the National Health Interview and Examination Survey. *European Child and Adolescent Psychiatry*, *17*, 22–33. doi:10.1007/s00787-008-1003-2

Rutter, M. (1980). *Changing youth in a changing society: Patterns of adolescent development and disorder*. Cambridge, MA: Harvard University Press.

Savage, H., Murray, J., Hatch, S. L., Hotopf, M., Evans-Lacko, S., & Brown, J. S. L. (2015). Exploring professional help-seeking for mental disorders. *Qualitative Health Research*. Advance online publication. doi:10.1177/1049732315591483

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis—Theory, method and research*. London, England: Sage.

Smith, J. A., Flowers, P., & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In L. Yardley (Ed.), *Material discourses and health* (pp. 68–91). London, England: Routledge.

Smith, J. A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative research* (pp. 53–80). London, England: Sage.

Weitkamp, K., Klein, E., Wiegand-Grefe, S., & Midgley, N. (submitted). *Therapy expectations of adolescents with depression entering psychodynamic psychotherapy: A qualitative study*.

Wittchen, H. U., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jönsson, B., . . . Steinhausen, H. C. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. *European Neuropsychopharmacology*, *21*, 655–679. doi:10.1016/j.euroneuro.2011.07.018

World Health Organization. (2003). *Caring for children with mental disorders—Setting WHO directions*. Geneva, Switzerland: Author.

World Health Organization. (2010). *International statistical classification of diseases and related health problems* (2nd ed., 10th rev.). Geneva, Switzerland: Author. doi:10.1016/j.jclinepi.2009.09.002

Author Biographies

Katharina Weitkamp is a researcher, systemic therapist, and lecturer at the MSH Medical School Hamburg, Germany. Her current research interest is in youth psychotherapy.

Eva Klein was a student at the MSH Medical School Hamburg, Germany at the time of the study. She finished her degree in psychology (MSc) and is currently in training for cognitive behaviour therapy.

Nick Midgley, PhD, is a child and adolescent psychotherapist based at the Anna Freud Centre and a lecturer in the Research Department of Clinical, Educational and Health Psychology, University College London (UCL), UK.