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How Adolescent Girls Understand and Manage Depression Within Their Peer Group: A Grounded Theory Investigation

Melissa D. Pinto-Foltz^a, Vicki Hines-Martin^b, and M. Cynthia Logsdon^{b,c}

^aCase Western Reserve University Frances Payne Bolton School of Nursing, Cleveland, Ohio

^bUniversity of Louisville School of Nursing, Louisville Kentucky

^cDepartment of Obstetrics and Gynecology, School of Medicine, University of Louisville, Louisville, Kentucky; Department of Psychological and Brain Sciences, University of Louisville Louisville, Kentucky

Abstract

Depression is prevalent among adolescent girls, but few receive mental health treatment. Adolescent girls often forgo needed mental health treatment because they fear responses of peers about depression. Understanding the processes of how adolescent girls respond to peers with depression is an important first step to improve access to mental health treatment. This qualitative study describes the knowledge, perceptions, and behaviors of adolescent girls about depression and mental health treatment within their peer group. The investigators conducted two focus groups, with adolescent girls (n=21), in a public high school in the southern U.S. Grounded theory methods were utilized to identify a beginning substantive theory about perceptions and behaviors of adolescent girls related to depression in their peers. Participants cognitively processed mental health concepts similarly to adults. However, their affective responses to peers with mental illness fluctuated between adult and child perspectives. Participants expressed concerns about individuals with depression that have previously been identified in adults, but expressed unique perspectives that reflect their transitional stage of development. Findings provide new information about how adolescent girls respond to peers with depression, define areas for further investigation, provide directions for constructing developmentally appropriate mental health educational interventions for adolescent girls, and elucidate the need to provide guidance to women with whom adolescent girls have sustained contact.

Keywords

Adolescents; Grounded theory; Qualitative; Depression; Mental health

It is estimated that eight percent of adolescent girls have a diagnosis of major depressive disorder (Logsdon, 2004; Beasley & Beardslee, 1998; Jellinek & Snyder, 1998). However, recent national population based surveys (2005 Youth Risk Behavior Survey) suggest that these depression rates among adolescent girls may be too conservative (Swahn & Bossarte, 2007). For example Swahn & Bossarte (2007) found that 41% of high school adolescent girls had clinically significant symptoms of depression, 24% had suicidal ideation, and 11% attempted suicide. Adolescent girls are twice as likely as adolescent boys to experience depression (Swahn & Bossarte, 2007; Cyranowski, Frank, Young, & Shear, 2000). Among girls, depression becomes markedly apparent between the ages of 13–15 and peaks at the

ages 17–18 (Commission on Women's Health, 1997; Fleming & Offord, 1990). Only 30% of adolescents who have depression receive needed mental health treatment (Samargia, Saewyc, & Elliott, 2006).

Untreated depression during adolescence carries severe and devastating short- and long-term consequences. Adolescents with untreated depression have impaired functioning in all domains, lower academic achievement, more unintended pregnancies, increased incidence of suicide, and are more likely, than adolescents without depression, to use substances like tobacco, alcohol, and illegal drugs (McCarthy, et al., 2008; Kuehn, 2005). Recent evidence links untreated depression during adolescence with the chronic health problems of infectious diseases, respiratory problems, and difficulty maintaining a healthy weight (Schinke, Fange, & Cole, 2008; Arons, et al., 2008). When depression is unresolved in adolescence, the long-term consequences of depression involve high health care utilization, poor overall health, and increased work impairment related to low physical health in young adulthood (Keenan, Miller, Hammen, & Brennan, 2007). Given these deleterious consequences, it is no surprise that depression is the leading cause of disability for those 15–44 years of age (World Health Organization, 2004).

Despite the profound and lingering effects of depression, it is alarming that few adolescents with depression receive needed mental health treatment (Samargia, Saewyc, & Elliott, 2006). Adolescents are concerned about their peers' responses to their depression; this concern influences adolescents' decision to seek mental health treatment (Wisdom & Agnor, 2007). Research by Marcell and Halpern-Felsher (2007) found that adolescents' preferences of seeking help for physical and mental health issues differ. Adolescents prefer to discuss physical problems with medical professionals and emotional issues with peers (Marcell & Halpern-Felsher). At the same time, adolescents fear rejection from their peers if they disclose depressive symptoms (Marcell & Halpern-Felsher). Woodgate's (2006) qualitative study with depressed adolescents is consistent with Marcell & Halpern-Felsher findings; depressed adolescents in Woodgate described feelings of fear and concern that they did not "belong in the world" because of social exclusion from peers. Conversely, when peers actively engage ("check in") with depressed adolescents, peers can assist depressed adolescents with seeking mental health treatment and in their recovery from depression (Woodgate). High peer support is associated with greater mental health treatment seeking in adolescents (Frojd, Marttunen, Pelkonen, Pahlen, & Kaitiala-Heino, 2007). Thus, adolescent peers can hinder or facilitate mental health treatment seeking (Wisdom & Agnor).

Since peer support and acceptance are influential to an adolescent's choice to seek mental health treatment, it is important to identify and understand the perspectives of adolescents' peer groups. Currently, it is unknown how adolescent girls respond to depressed peers within their peer group. Understanding the response of the adolescent peer group is essential to building an evidence base that will inform the design of educational interventions and therapeutic interventions that improve access to mental health treatment for adolescents. Qualitative studies with the target population, adolescents, support and inform evidence-based practice by illuminating the *human response* to health situations and the *meaning* (or how people make sense of health concerns). Both *human response* and *meaning* can be used in evidence based practice to guide therapeutic interventions and individualized holistic care (Grace & Powers, 2009). Thus, the purpose of this qualitative study is to describe the knowledge, perceptions, and behaviors of adolescent girls, with no diagnosis of clinical depression, regarding the management of depression within their peer group.

Method

Setting and Sample

The study was set in one public high school located in a southern urban area of the United States. Students were predominantly middle to lower socioeconomic level (27% of enrolled students participated in the free or reduced school lunch program) and Caucasian. Similar to the racial/ethnic minority distribution of the larger community, African American adolescents are the largest minority population in the school and surrounding community and accounted for approximately 21% students attending the school. The target population was adolescent girls who attended the public high school.

Procedure

University and high school system IRB approval were obtained prior to initiating study procedures. Participants were recruited through the school's health and physical education courses. The principal investigator visited all ninth grade girls in their health and physical education classes and provided a short presentation that detailed the study. Interested and eligible adolescents were provided a consent form packet. Adolescents were instructed that signed adolescent assent and parental consent were mandatory for study participation. The investigator encouraged adolescents to have their parent read and sign the consent form packet and return the packet to a designated school counselor within one week. The investigator retrieved the consent and assent forms from school counselors a week following study recruitment and verified forms for parental and adolescent signatures prior to data collection. Adolescents received a \$15 gift card to a discount retail store for study participation.

All subjects (n=21) enrolled in this study were in the ninth grade, and the mean age was 14.33 (SD=.483, Range=13–15 years of age). The sample distribution of race was reflective of the school and larger community. Seventy-six percent (n=16) of adolescents were Caucasian, 20% (n=4) were African-American, and less than one percent (n=1) was Asian/Pacific Islander. Most participants resided in two-parent homes (n=16), while other participants resided in mother (n=6) or father only (n=1) homes.

Data Collection

Data were collected utilizing two focus groups (n=10, n=11). Focus groups were conducted during school hours and in a private location within the school. Focus groups were one hour in length, and guided by a semi-structured interview guide that covered the domains of behavior, feelings, and cognition related to depression and peer relationships. See Table 1 for a description of interview guide. Focus group sessions were audio taped and transcribed verbatim by a professional transcriptionist. Two investigators were involved with the conduct of the focus groups. During each session, the investigators generated written field notes describing the content of each session, responses of individual participants, and the investigator's reflective thoughts about the focus group session. Demographic data on age, race/ethnicity, and family structure were also collected from participants.

Data Analysis

Using grounded theory methods (Glaser & Strauss, 1976; Glaser, 1978), data analysis began with review of the verbatim transcripts to assure accuracy. Data analysis consisted of open, axial, and selective coding, schematic diagramming and comparison of study findings to findings in existing literature. Each focus group transcript was first analyzed individually, with subsequent comparative analysis between the data generated from the two groups. During open coding, the investigator read and re-read the transcripts in their entirety multiple times. Codes (or labels) were designated for all content that appeared to represent a

thought, feeling or behavior related to depression and peer relationships. Next, line-by-line coding and constant comparative analyses were utilized throughout this process. For open coding, data were reduced into smaller segments and assigned into categories. Through this process, repetitions in codes and responses were revealed. Then, axial coding was performed. Axial coding moves the analysis from the level of description of what was (and how many) described a given perspective or behavior to more fully presenting relationships such as concerning conditions, context, action/interactional strategies and consequences. To determine the core categories and validate relationships, selective coding was performed. Core categories are the basic social processes that differentiate and account for the perceptions and behaviors related to peers and depression. Selective coding involves the identification of codes that are most robust, identifying if they can be combined to provide a broader understanding of the phenomenon. Those codes with lesser support are eliminated. This process lays the foundation for the developing theory of how the phenomena is constructed using the data generated by the participants. From this data analysis process, substantive (or data driven) theory was identified regarding what adolescent girls understand and feel about depression, how they view their peers, and what behaviors they use in relation to peers with depression. A schematic that exemplified the emerging conceptualization of the data was created. To ensure a parsimonious model, the investigators revisited the schematic several months after its initial creation to verify that all core categories, subcategories, and their connections were necessary and in the simplest form. Finally, the generated substantive theory was compared to extant literature in relation to similarities and dissimilarities in study findings. These comparisons are presented in the discussion section of this paper.

Criteria for Scientific Adequacy

Demonstrating scientific adequacy (also called trustworthiness) is important to support the rigor of qualitative research studies. Methodological techniques that support scientific adequacy of the study and the resulting findings were based on criteria set forth by Lincoln & Guba (1985) and include credibility, dependability, confirmability, and transferability. Credibility is confirmed over time by demonstrating consistency of results in different samples. Credibility begins by determining how believable the participants find interpretation of the results (Lincoln & Guba, 1985). Thus, credibility is supported by immersion and “member checks” (Lincoln & Guba, 1985). Credibility was supported in this study by the investigator’s immersion in the data, the investigators repeatedly listened to the audio recordings. The investigators performed “member checking” with participants at the conclusion of each focus group session. The second author, an expert in grounded theory research, verified coding from each transcript and theory development throughout the analysis. At the conclusion of data analysis, the investigators surveyed the literature and examined how study findings compared with, but extended the scientific literature in this area. Dependability is how the research process is made open and accountable by the use of record keeping (Lincoln & Guba, 1985). A record of memos, written throughout the analysis, supported dependability. In addition, field notes were utilized as an audit trail and described the investigators’ reflections, decisions, and interpretations during the study. Confirmability is the ability of the researcher to remain objective and neutral and disclose preconceived ideas or perspectives a priori (Lincoln & Guba, 1985). Confirmability was supported by the investigators’ practice of “unknowing,” and bracketing of preconceived ideas about known unfavorable attitudes about depression treatment. The investigators were self-reflexive or cognizant of the relationship among themselves, the participants, and everyone’s role in the study (Lipson, 1989). To support confirmability, as recommended by Cutcliffe (2003), the investigators considered these relationships and understood that their presence in the room during the focus group may have affected responses. The investigator recorded field notes about participant non-verbal behaviors during data collection as

additional data that could be reviewed. Nonverbal communication (facial expressions, head nodding, etc.) in relation to interview questions is an important adjunctive resource in focus group research. These notes were examined in relation to the transcript. Although data was limited to two focus groups, there were many repetitive perceptions, thoughts, and behaviors identified as a result of the analysis. Consistency of responses between members of both focus groups was evident. Transferability is the ability of the researcher to provide a detailed and in-depth picture of specific circumstances of their research so others can utilize findings in a different context (Lincoln & Guba, 1985). Transferability regarding how this study can be utilized to glean insight into depression in adolescent girls' peer group is detailed in the discussion section.

Results

The findings are presented in one overarching theme, which we labeled “dual nature,” along with three subcategories, which we labeled “adult concerns,” “child concerns,” and “concrete nature.” We defined dual nature as to how participants could cognitively process mental health concepts comparable to adults, but their affective responses to peers were dynamic and fluctuated between those of an adult and child. We define adult concerns about peers as concerns that relate to the physical risky behavior resulting from depression. We define child concerns about the developmental tasks of adolescents-social integration, being similar to others, and being accepted. We define concrete nature as the superficial thought processes that occurred as participants determined what actions to take (or not to take) with a depressed peer. Table 2 provides a description of the overarching theme and core categories. Also, all themes and core categories are discussed in greater depth in subsequent sections.

Dual Nature

The overarching theme was *Dual Nature*. *Dual Nature* describes how participants could cognitively process mental health concepts in ways that are comparable to adults, but their affective responses to peers were dynamic and fluctuated between those of an adult and child. When asked, “What do you think about your peers with depression?” Participants responded with statements that reflect their complex (Dual) perspectives regarding depression:

(Child nature) “It’s like, it’s like if you’re good friends with that person [with depression], you would understand them and see the difference, but if you start to get mad at them, and they did something wrong to you, then you’re going to bring that [knowledge about peer’s depression] back on purpose, to like, make fun of them.”

(Adult nature) “It’s (depression) not something you throw around, even though if it’s not (major depression), if it’s mild depression, or like severe depression or middle, it’s still not something to throw around [when talking about a peer].”

Adult Concerns—Eleven participants provided narrative data that we labeled adult concerns. Adult concerns focused on concerns about their peers related to the physical risky behavior resulting from depression-self-harm and suicide attempts. Specifically, participants searched for a deeper meaning in the physical risk behavior of their peers. Participants attempted to cognitively process the behaviors by formulating reasons for the physical risk behavior. Often the reasons and concerns surrounding physical risk behavior of peers were attributed to poor family relationships.

“One of my girlfriends, ah, her parents really didn’t like not give her attention because they didn’t love her; they did it when they had time...so that’s what it ended up being. I don’t

think she really meant to really kill herself or anything, but she just got upset, and she didn't tell anybody."

Another participant recalled a second hand account of a physical risk behavior of a peer and attributed the cause to the peer's family relationship. "My best friend, she had a friend...that just got out of the hospital. I heard she didn't get along with her parents and everything, and so she went down there and hung herself."

Participants were intensely curious and concerned about physical risk behaviors of their peers. One subject asked the investigator, "Are they (depressed peer) more likely to just hurt themselves [sic] or will they hurt other kids?" Another participant quickly answered by saying, "I think they are just trying to get some help." Still another participant added, "I think they just want attention."

Relationships with significant others, especially peers and romantic partners, were also of concern; the overwhelming majority of participant responses focused on the importance of these relationships. "I wouldn't tell my boyfriend (I was depressed) either. He might think I am crazy." Another participant said, "I think for some people that weren't really friends, they would try to turn their back and not talk to her [depressed peer] as much and try to just fade away slowly."

Child Concerns—Fifteen participants provided narrative data that we labeled as concrete nature. Child concerns were defined as concerns that reflected the developmental tasks of this age group (social integration, being similar to others and being accepted). Within the same discussions of adult concerns, adolescents would swiftly shift their thoughts to child-like concerns, like being similar and dissimilar to their peers. When asked how others act toward a depressed peer, a participant said, "I think sometimes you get influenced by others. Even if you think that they (depressed peer) are okay and they're not weird or anything...but then, if you hear, like, people around you make fun of them, then you start to think they're weird. You start just because your others friends think it." Participants described adolescent girls who exhibit depressive symptoms as "weird," "crazy," "psycho," and "mental."

Concrete Nature—Sixteen participants provided narrative data that we labeled as concrete nature. Concrete nature was used to reflect the superficial thought processes that occurred as participants determined what actions to take (or not to take) with a depressed peer. Participants could list depressive symptoms, but could not connect these symptoms to depression—a mental disorder that needs intervention. Importantly, participants noted they would not intervene to help a depressed peer until symptoms were outwardly visible through specific physical behaviors and were considered "serious." One participant remarked, "Yeah, it's like they [depressed peer] are going crazy and if they'd eventually kill themselves [sic], I'd be kind of freaked out (more) than if it just something little. Then I'd help them." Several participants offered to assist a peer with depression: no participants could identify more than one way help to assist peers.

When participants described intervening to assist a depressed peer, all participants said their first approach would be to "go tell an adult." Specifically, participants identified mothers, and women teachers, counselors, and athletic coaches as front line contacts for assistance. One participant said, "I would get my mom to tell me what she thinks (if I have depression or not)." Another participant concurred, "Yeah, cause your mama knows you."

Participants repeatedly described, and were focused on, concrete actions, like "cutting," and anorexia nervosa, that reflected mental disorders or depression. Participants called adolescents who cut their bodies (especially their arms), "cutters," and those with anorexia

nervosa, “Annies.” One participant said, “I think that sometimes people think that their depression is so bad that they need something (cutting) to overcome it, so they do that to get away from the depression. It gives them something else to do.”

Another participant told a story about how witnessing symptoms of anorexia nervosa as a child made a lasting impression,

“One time I went over to my friend’s house. And her sister, she’s a nice person, and she became friends with this anorexic girl, and my friend saw my reaction to the way she looked. And I was just, like, did I ever say anything? She was super skinny. When we all sat there and had a cookie, she just drank water. I was confused and my friend took me outside and told me that she was anorexic, and I was like in the fifth grade and I didn’t know what that means. But then, I was like, after I processed it in my mind...I was like, she had a disease and was really skinny and until this day I still look back and like she is anorexic. I can’t get it out of my mind. If I was to see her today, I would still be like she’s anorexic, she was. And that’s how a lot of people feel [about mental illness].”

Discussion

Findings indicate that adolescent girls still have unanswered questions about depression, other mental disorders, and their personal relationships with peers with mental disorders. Participants were forthcoming with stories about depression and other mental disorders and were also intensely curious about the behavior of their peers. Specifically, adolescent girls asked questions about mental disorders and requested explanations of their peers’ actions and behaviors. This finding suggests that adolescent girls desire more education about mental health. When adolescent girls were asked general questions about mental health, they associated depression and mental disorders with suicide, cutting themselves, and anorexia nervosa. All of these physical risk behaviors are concrete, have visually observable outcomes, and are considered by adolescent girls as “serious.”

Like the findings of Burns and Rapee (2006), adolescent girls accurately articulated signs and symptoms of depression, but they could not apply this information to a personal situation. When depressive symptoms were present in their peers, adolescent girls in this study could not link the symptoms to depression, a mental disorder that needs professional evaluation and intervention. Consistent with the adolescent literature (Wisdom & Agnor, 2007; McCarthy, Downes, & Sherman, 2008), adolescent girls in this study viewed trusted adult role models who were women—mothers of adolescents, teachers, and athletic coaches—as resources to protect their peers from physical risk behaviors or what participants called “serious” behaviors.

The solutions adolescent girls proposed to depression were more child-like than their identification of depressive symptoms. Adolescents girls described passive referral of peers for mental health (by telling an adult about their peer without their peer present), and did not indicate active referral (by accompanying their peer to an adult who can assist them), even for physical risk behavior. These findings are similar to Kelly, Jorm, and Rodgers (2006) in respect to adolescents in our study suggesting passive referral for depression. On the other hand, our findings are inconsistent with Kelly, Jorm, and Rodgers’ findings with respect to active referral for behavior problems and when physical safety is of concern. Despite physical risk behavior among peers, adolescent girls in the current study reported they would not initiate active referral.

Limitations

Findings of this study should be interpreted with caution. The study was limited by a small sample size and use of one data collection site. Participants in this study were interviewed at one point in time. In addition, the age range of focus group participants may have affected responses. It is plausible that participants and the public high school in this study were not representative of the broader adolescent girl population and other public high schools. Finally, there may be selection bias. Participation in this study was voluntary and required informed parental consents, adolescents who participated in this study may be different from those that did not participate.

All study investigators were from the same discipline. It is possible that researchers from other disciplines may have viewed and interpreted the data differently. For example, our analysis did not include the impact of culture, social policy, or gender inequities as possible explanations of our findings. This can be considered an additional limitation.

Implications for Science and Practice—In spite of these identified limitations, the findings from the study add to the current literature on adolescents and depression. Our findings build upon previous work of others (Wisdom & Agnor, 2007; Chandra & Minkovitz, 2007; Draucker, 2005) by systematically categorizing the personal experiences of adolescent girls related to depression in their peers. Adolescent girls recalled stories about depression and what *actually* occurs within their peer group.

This study advances scientific knowledge about barriers to depression treatment in adolescent girls. Clearly, lack of knowledge related to how to provide peer support is rampant. At the same time, acceptance and support by peers is important to adolescent girls with depression. Findings suggest that interventions may need to (a) help adolescent's link inappropriate behavioral cues, consistent with mental disorders, to an illness that needs intervention; (b) help adolescent's identify appropriate solutions and avenues for seeking mental health treatment and assistance for their peers; (c) include all collateral individuals serving as role models, especially women teachers, athletic coaches, and mothers of adolescents; and (d) foster acceptance and support for peers with depression and other mental disorders

This study also adds to the science by providing initial data about the level and type of mental health information needed for adolescents. Also, this study provides information about the acceptability of mental health information to adolescent girls similar to those in the current study; and elucidates how and under what circumstances adolescent girls may take action to assist and ensure safety of their peers and who adolescent girls would involve in this process. Importantly, this study informs the methodological approach for providing mental health information and designing mental health interventions for adolescents. Based on these findings, adolescents need concrete information that may include pictures, personal narrative stories from those with mental disorders, creative arts/drama, and visual media to improve their knowledge and identification of behavioral cues consistent with mental disorders. Adolescents need an established plan to assist peers with mental disorders. This may be accomplished by assisting adolescents in developing an individualized plan to facilitate referral for mental health treatment. Role-play and practice of this plan may improve confidence and the adolescent's ability and comfort in obtaining mental health treatment.

Implications for Future Research—Findings from this study also raise many questions and areas for future investigation. Future studies are needed to further validate the findings of the presented research. Building on this study's findings could support the development of studies that explore accessibility, acceptability, appropriateness, and effectiveness of

educational programs with adolescent girls. Because adolescents are peer focused and are influenced by their peers, universal school-based interventions, which increase peer support and acceptance of depression and mental disorders, appear indicated. Finally, women serve as influential figures for adolescent girls in this study. Thus, understanding the affects of these women (particularly mothers of adolescents) on adolescent girls' mental health concerns and behaviors are essential for improving mental health outcomes of adolescent girls.

Conclusions

Youth are exposed to depression and other mental disorders within their peer group before they reach adolescence (Hennessy & Heary, 2009). We also found this to be true in the current study; however, adolescent girls in the current study did not have accurate and adequate mental health knowledge. Importantly, this lack of mental health knowledge may contribute the inability of participants to articulate appropriate interventions for helping themselves and others with mental disorders. This study provides a substantive theory that may guide the development and approach to mental health education and interventions with adolescents.

The National Academy of Sciences Committee on Adolescent Health (2008) recommends that health care interventions are accessible, acceptable, appropriate, and effective for adolescents. The current study provides initial data that contribute to these recommendations for mental health interventions.

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Figure 1.
Process by which adolescent girls understand and manage depression within their peer group

Table 1

Description of Interview Guide

Domain	Description	Sample Question
Behavior	How adolescents treated peers with depression (2 core/2 probes)	How would people look at you if they know you are depressed?
Feelings	How adolescents expressed emotion related to depression (2 core/3 probes)	How do you think you would feel if your friend told you they thought they were depressed?
Cognition	What were adolescents level of knowledge about depression (1 core/4 probes)	What do you know about depression?

Table 2

Description of Overarching Theme and Core Categories

Overarching Theme/Core Category	Description
Dual nature	How participants could cognitively process mental health concepts comparable to adults, but their affective responses to peers were dynamic and fluctuated between those of an adult and child.
Adult concerns	Concerns that focused on adolescent peers which related to physical risky behavior resulting from depression (self-harm and suicide).
Child concerns	Concerns that were related the developmental tasks of the age group (social integration, being similar to others, and being accepted).
Concrete nature	The superficial thought processes that occurred as participants determined what actions to take (or not to take) with a depressed peer.