

“More Worries Kept on Coming and Coming”: An Interpretative Phenomenological Analysis of How Early Adolescent Girls Experience Emotional Symptoms

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Abstract

Objectives: We sought to explore the subjective ways that at-risk early adolescent girls experience and make sense of emotional symptoms, characterised by depressive and anxious feelings. Research indicates higher rates of emotional symptoms and disorders among girls and women, and recent evidence indicates increasing prevalence among adolescent girls, warranting exploration of subjective experiences.

Methods: Interpretative phenomenological analysis (IPA) was used to explore lived experience and sense-making. This approach aims to capture rich, in-depth insight into the way in which a small number of early adolescent girls subjectively understand and experience these types of symptoms. In-depth interviews were conducted with three early adolescent girls who described experiencing emotional symptoms and exposure to multiple sources of possible stress.

Findings: Five themes were developed to capture participants' experiences of symptoms: (a) the nature of symptoms, including differing conceptualisations of symptoms as objectified cognitive entities or an affective state; (b) symptoms are a collective mass that can grow, which can sometimes mean they go beyond one's control; (c) symptoms as central and dominant in emotions; (d) passive experience of symptoms, whereby participants often considered themselves passive within occurrence and resolution of their symptoms; and (e) grappling with symptoms in relation to the self, which captures the separation participants created these feelings and their core identities.

Conclusions: Early adolescent girls can experience symptoms as intense and at times uncontrollable, and may find it difficult to align these difficulties with their sense of self. It may be therapeutically valuable to support this group in understanding and making sense of these thoughts and feelings in order to facilitate a greater sense of control.

Background

Research indicates that from early adolescence, girls become more likely than boys to experience emotional symptoms, characterised by depressive and anxious feelings (1, 2). This disparity appears to persist throughout the lifespan. Girls and women are twice as likely as men to report depressive symptomatology and disorder from mid-adolescence and at greater risk overall for anxious symptoms and disorders, with some fluctuation across anxiety type (2, 3). This vulnerability is understood to be attributable to complex interactions of contributors across biological (e.g., adrenal hormones), psychological (e.g., greater tendency for ruminative coping), and sociocultural (e.g., gender-related violence) domains of girls and women's lives (1, 2, 4). Worryingly, recent evidence suggests increased levels of emotional symptoms and disorder among adolescent girls in the United Kingdom (5–9) and other Western and non-Western countries (8, 10–17). There is little clarity regarding the cause(s) of this apparent increase, though researchers have posited contributors including social media usage, increased sexualisation of adolescent girls, and intensified academic pressure (5, 7, 8).

Given that adolescent girls appear vulnerable to emotional symptoms and disorders, perhaps increasingly so, there is a need for research exploring current experiences of such difficulties among this group. We set out to explore how emotional symptoms are perceived by early adolescent girls; that is, how these symptoms actually appear and feel to those experiencing them. Qualitative exploration of this felt experience can illuminate the way that individuals think about and make sense of their symptoms, which may offer valuable insight for practitioners and therapists. Such insight may also provide insight into how girls' understandings might influence decisions and responses in relation to symptoms, in turn informing practitioners in supporting symptom management among this group.

To date, there has been modest qualitative exploration of the ways adolescents that experience and understand mental health, including emotional symptoms. Some studies have examined subjective depression experiences, offering insight into how such difficulties are perceived (18–24). This includes, for instance, indications that adolescents have different ways of conceptualising the variety of symptoms under the umbrella term “depression” (19, 22), that they may experience bewilderment in understanding where difficulties come from (18, 19, 21, 22, 24), and that depression can create identity shifts (18, 20, 22). Further research is needed, including a focus upon both depressive *and* anxious symptomatology, given that the two are often experienced jointly.

We extend research in this area by focusing on the lived experience and sense-making of emotional symptoms among early adolescent girls. Despite their well-documented vulnerability, there is little exploration of adolescent girls' experiences in particular, with the exception of a study by Shaw et al. (23), which examined the lived experience of adolescent girls being treated for depression through English child and adolescent mental health services (CAMHS). However, this study stands alone and is now dated, warranting further exploration with a more recent sample, especially given indications of rising difficulties among adolescent girls. Existing studies also frequently focus on individuals receiving treatment for depression through CAMHS; exploration of the experiences of a community sample experiencing symptoms not necessarily being treated as a “disorder” would further augment understanding.

The current study uses interpretative phenomenological analysis (IPA), a methodological approach used to explore how individuals make sense of their experience of a given phenomenon (25–28). In IPA, the researcher elicits personal accounts of lived experience and develops rich experiential themes that describe and interpret experience and sense-making. We focus specifically on “at-risk” early adolescent girls; that is, those experiencing emotional symptoms in the context of exposure to multiple risk factors and sources of stress. This is due to the study being part of a broader programme of research exploring emotional symptoms in the context of risk and adversity, undertaken within the evaluation of HeadStart, a longitudinal project focused on the mental health and wellbeing of young people in disadvantaged areas of England.

Methods

Participants

The study focuses on accounts from three early adolescent girls in England: Amelia, Jennifer, and Grace (pseudonyms). IPA typically focuses on a very small number of cases due to its idiographic commitment and the intensity of analysis; our focus on three cases is in line with guidance that a small number of cases can offer rich idiographic depth and representation of more nuanced findings (26, 28, 29).

Participants engaged in qualitative interviews as part of the main project, and were identified for inclusion in these interviews by school staff. These particular participants' accounts are explored here as each focused on thoughts and feelings typically associated with emotional symptoms within their interviews, as identified for the purposes of the current study by the first author and reviewed by the third author (a child and adolescent psychotherapist). Given the wider project's interest in adversity and risk, participants were also selected based on their self-disclosed exposure to three or more "stressors", identified in their accounts based on either self-perceived sources of stress and/or empirically evidenced risk factors, (variables associated with greater likelihood of negative outcomes e.g., victimization, academic difficulties, poor maternal relationship).

Amelia

Amelia was 12 years at the time of her interview and identified herself as White British. She lived with her parents and her brother in a disadvantaged urban area. Amelia described feeling anxious and having "worries" on a daily basis and explained that this frequently caused her distress.

Jennifer

Jennifer was aged 12 years and identified herself as Asian. She lived with her parents and two younger siblings in a disadvantaged urban area. Jennifer said that she frequently had "negative thoughts" and described recurrent feelings of anxiety.

Grace

Grace was aged 12 years and identified herself as White British. She lived between her parents' separate homes in a disadvantaged urban area, with her father as her main guardian. Grace described feeling upset, anxious, and stressed on a daily basis.

Materials And Procedure

Experiential accounts were gathered through audio-recorded interviews in participants' schools. Interviews were semi-structured, wherein researchers are guided by an interview schedule but are responsive to participants' narratives. This is the preferred method for IPA as it facilitates detailed experiential accounts (28). Participants were asked questions about various aspects of their lives, including how they experienced and coped with different emotions and problems and their perceptions and experiences of sources of support. For example, emotion questions included "what sorts of feelings

or emotions do you experience when you are not feeling happy?” and “what kinds of things can make it harder or more difficult for you to feel happy?” Prompts were utilised to elicit detail and clarity (e.g., “how does this lead to you feeling that way?”). Participants received a £10 shopping voucher as a gesture of thanks.

Ethical Considerations

Ethical approval was granted by University College London (Ref. 7963/002). Participants and parents/carers received information sheets and gave informed consent. Accounts were anonymised during transcription. Interviews were undertaken with adherence to safeguarding policies and procedures.

Analysis

Participants’ accounts were analysed by the first author using IPA, following the six-stage framework outlined by Smith et al. (28). The analytical process was carried out using pen and paper rather than software to facilitate closeness with the data (28). The first four stages are carried out individually for each participant, with each case approached afresh rather than influenced by analysis of previous cases. Here, the researcher first immersed themselves in the account, reading the transcript several times and listening to the audio. They then systematically coded the transcript, with attention to descriptive, linguistic, and conceptual features (28). Next, they developed emergent themes, considering both the transcript and the initial coding, which at this stage are considered jointly as an expanded dataset (28,30). They then explored and grouped emergent themes into a refined set of experiential themes for that participant.

Stages one to four were repeated for all three participants, with each transcript analysed individually. The researcher sought to ‘bracket’ analysis of previous cases to limit their influence on each individual account as much as possible, in line with IPA’s idiographic emphasis. Finally, once all cases were analysed, each individual’s themes were brought together into higher-order themes representing experiences and sense-making across all cases (28).

Analysis and reporting was conducted in line with IPA quality guidance (26,28) and quality guidance for qualitative research (31,32), namely sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Several strategies were utilised to facilitate reflexivity, a key consideration within IPA (26,28), through ongoing documentation of reactions to the data, use of bracketing techniques during coding, and peer discussion. Note that this study reports themes specifically related to symptom experiences; other themes, such as those focused on support mechanisms, are to be reported separately (Authors 1 and 2, in preparation).

Findings

Five themes were developed to capture participants’ experiences of symptoms: (a) The nature of symptoms (object or state); (b) symptoms are a collective mass that can grow; (c) symptoms as central and dominant in emotions; (d) passive experience of symptoms; and (e) grappling with symptoms in

relation to the self. In reading the account of findings presented here, the reader should note that “symptoms” is used broadly in describing participants’ experiences. Though this term captures a clinical construct not immediately aligned with the study’s focus on felt experience, participants used both affective and cognitive terminology in their accounts. Thus, participants’ phrasing is used where appropriate, while collective experiences across the sample are broadly discussed as “symptoms” and, within this, “feelings” and “thoughts” for affective and cognitive experiences, respectively.

The Nature of Symptoms (Object or State)

Participants conceptualised symptoms differently, but these largely fell into two categories; firstly, a tangible and objectified object that one “has”, or secondly an affective state that is more encompassing of the self. In terms of the former, both Amelia and Jennifer understood and presented their symptoms as distinct and tangible entities that could be defined and named, using noun labels. Amelia described having “a worry” or “worries”, generally underpinned by a fear that something bad was going to happen; “about my worries, say, like, will this happen or what will happen if I do this?” Jennifer instead described having “a negative thought” or “negative thoughts”, often about herself: “I kind of have negative thoughts, like, I’m not going to do well and stuff like that [...] I think that I’m not good enough, and like... that... mmm... yeah, I’m just not good enough.” Such labels offer a sense of symptoms as cognitive rather than affective in nature and gave a sense of objectification, wherein there are thoughts that are *had*, rather than something that is felt or embodied. This objectification was often present when the two talked about managing a thought once it had arisen, as was particularly evident when Amelia explained a strategy in which you “flick” away a worry: “If it’s on your shoulder, like, just flick it off and then the worry will go away.” Such statements add to the sense of the experience of *tangible entities* that can be passed along or flicked away. This apparent objectification was added to by both participants talking about these thoughts as occurring both singularly and pluralistically; for instance, Jennifer talked about having “a negative thought” about a specific issue but also used the collective “negative thoughts”.

Grace, however, did not use this kind of language to describe symptoms, and instead talked consistently about these feelings as an emotional state that she could be in or could become, referring to instances where “I get really upset”. In some other instances she described feeling something, such as “I was feeling stressed”. This kind of language gave the sense that Grace experienced these feelings as all-encompassing and saturating the nature of her being at that moment, rather than having a more separate and isolated quality. Thus, Amelia and Jennifer described thoughts that they considered to be tangible entities separate from their “self”, while Grace talked of feelings that constituted a deeper alteration to the state of the self.

Symptoms are a Collective Mass that can Grow

All participants described experiencing the thoughts and feelings associated with their emotional symptoms as forming a singular mass that could grow and build inside of them. Amelia and Jennifer switched frequently between singular and plural conceptualisations of “worries” and “negative thoughts”, which indicated that although they had concerns about singular aspects of their lives, these could be

thought about as occurring collectively. For instance, Amelia talked often about singular “worries” relating to specific things, such as keeping up in class, but she also consistently described these as the collective “my worries”. Similarly, Jennifer described specific negative thoughts, such as that people do not like her or that she is not achieving, but also offered a more general commentary on these feelings as a collection of “these negative thoughts” or simply “them”. Indeed, on a number of occasions she switched to calling these thoughts “it”; for instance, when asked whether she has spoken to anyone else about these negative thoughts, Jennifer replied, “erm... no I keep it inside.” Thus, it seems that though a singular thought or feeling can occur by itself, these can also be thought of as occurring collectively as a distinct feature of one’s life world.

This mass of symptoms could, at times, build and grow, at times becoming unmanageable. For Amelia, who talked about herself as someone who had “lots of worries”, this process seemed, as if by mitosis, wherein her thoughts could multiply if left unchecked: “I forgot to flick it [the worry] off that’s why more worries kept on coming and coming.” Such comments gave a sense of internal multiplication beyond Amelia’s control. Similarly, although Grace did not make sense of these feelings as being singular or plural but a more general emotional state, she reflected that her emotions can become “too much” or “too hard” to deal with. Grace frequently described this combination as building until it reached “a certain point”, where the demands and feelings she was experiencing would become unmanageable for her as in the following excerpt:

I used to self-harm myself, it used to get pretty, like... I used to get so bad [...] I didn't know what else to do, I was just getting so mad [...] I was feeling angry, I was feeling stressed... and like, I didn't know what to do anymore.

Grace’s statement that “I didn’t know what to do anymore” illustrates her feeling that she is unequipped to manage this heightened level of emotional turmoil. Indeed, her use here of several “feelings” words – mad, angry, and stressed – gives a sense of her intense emotional state and provides insight into how overwhelming these experiences could be for her. Thus, it appears that the thoughts and feelings associated with symptoms may arise in relation to specific situations but merge into a wider mass which can grow to become intense and, at times, unmanageable.

Symptoms as Central and Dominant in Emotion Experience

This theme captures the way that Amelia and Jennifer’s talk of “worries” and “negative thoughts” appeared to dominate the emotional discussion within their accounts. It should be noted that Grace did not centralise these specific types of feelings in this way, talking more widely about her emotional experience, and so this theme represents the experiences of only Amelia and Jennifer.

For Amelia and Jennifer, there was a strong sense throughout their accounts that “worries” and “negative thoughts” were central to the participants’ general emotion experience. Talk about these feelings dominated their overall accounts, with participants focusing on symptoms in response to questions specifically relating to emotions as well as questions about broader day-to-day life. Indeed, accounts of

their daily lives suggested that these feelings are often present and are a defining feature of how they engage with others, and where the conversation began to move away, both participants would quickly move back to discussing symptoms. It is notable that interviews were broadly designed to focus on how participants experienced life and how they dealt with difficult problems and emotions, meaning that this emphasis on symptoms was broadly led by the participants themselves. Thus, such a consistent focus suggests that symptoms serve as a substantial component of these two participants' daily lives. This was illustrated in a diversion Amelia took after being asked about her family:

I like being like, with my family on a night time and just relaxing chilled out with like no stress and homework that I'm also worried about if like I get it wrong or if it's late... because, erm, shall I give you an example of like homework when I was worried?

Furthermore, for both Amelia and Jennifer it seemed that even emotions like happiness or feeling calm were defined as the absence of these symptoms, as in the quote from Amelia's account above, which was a response to a question about why spending time with her family made her feel happy. Indeed, when asked what it is like to be happy, Amelia stated, "really like happy not worried about anything". Jennifer seemed to view this relationship between these different types of emotions as though happiness was a baseline, or a true self, that was interrupted by the presence of her negative thoughts:

[Interviewer: During times when you haven't thought that you're a failure, what's, what's been different about those times?] *Erm, I'm happy, and... yeah I'm just, more myself*

Thus, there appears to be oppositional conceptualisation of these different types of emotions, in which happiness is the absence of a "worry" or a "negative thought" and can be removed or disrupted by these symptoms.

Passive Experience of Symptoms

Participants appeared to view themselves as largely passive within both the occurrence and the resolution of their symptoms, and experienced tension in relation to how symptoms related to themselves and their identity. Both Amelia and Jennifer had difficulty articulating how and why these feelings were occurring. For instance, Jennifer frequently appeared to find it difficult to comprehend the underlying reasons for these thoughts, as they often did not seem to make logical sense to her:

I'm never really happy even though I got... high, 'cause like, I got an A in Science and, stuff like that [...] I don't know, I'm never happy, with myself. I mean I am but like, sometime... I'm never happy with like, the grade that I get, I don't know. But I am happy with myself, I guess.

Unlike Amelia and Jennifer, Grace had less difficulty in identifying where her feelings came from, drawing direct links between her internal distress and areas of her external world which she was finding difficult, such as a difficult relationship with her mother. In this way, Grace's passivity was not in relation to an absence of understanding of where these feelings came from, but was borne out of a lack of control over

those causes; she herself was not choosing to feel this way, it was simply an inevitability given the various challenges she faced.

Amelia, Jennifer, and Grace also appeared to consider themselves unable to actively and effectively regulate and respond to these symptoms once they had arisen. For Amelia and Grace, this extended to making use of those around them to help them manage and resolve these symptoms, as they seemed to feel unable to do so independently. For instance, Grace described keeping a feeling within her until she could talk to a trusted other, usually her dad. It appeared in this way that Grace saw herself as only able to contain and hold the feeling, rather than actually do anything with it or resolve it, which would require another person: "I keep it into myself all day, and then I'll go home and talk to my dad."

Where participants did talk about taking steps to resolve symptoms, they did not present themselves as active in these actions. They seemed to find it difficult to articulate why they took the steps they did, or to feel that it was the only option available rather than being a choice. Jennifer talked about eating comfort food "for some reason", while Grace talked about self-harming because she "didn't know what to do anymore". Indeed, they seemed to believe that these strategies often did not work, adding to a general sense of helplessness in relation to symptoms. When the interviewer asked Jennifer how eating comfort food helped, for instance, she responded: "N-, it doesn't help, at all, but, you just think that it will, but, it won't. Like, eating comfort food, it won't help you, at all." Thus, it seems there are times that participants adopt strategies that can provide only a temporary release or none at all, in the absence of more effective strategies.

Grappling with Symptoms in Relation to the Self

Across all three accounts, there was a juxtaposition of connection and separation between symptoms and the self. There was a general sense that symptoms originate and exist internally, even where they are considered beyond one's control. For instance, Jennifer often explained that these thoughts are something that she feels she should "keep inside and don't wanna tell anyone else", while Amelia and Jennifer talked about thoughts and feelings being in their heads: "sometimes I just like forget, like, still have my worries in my head" (Amelia). Such efforts to *keep* a feeling inside indicate that this is where it is believed to have originated in the first instance, suggesting some connectedness with the self. Furthermore, although Amelia and Jennifer did invoke separateness in their talk of *having* worries and negative thoughts, they still presented these thoughts as tied to them through possessional language, such as Amelia's use of "my worries".

Nevertheless, participants also established a level of distance from their core "self", or identity. At times this was indirect, such as the passive ways in which participants viewed themselves within the process of such symptoms or the objectification of one's thoughts as tangible entities that are *connected* to, but not a *part of*, the self. However, there were also several ways in which participants directly invoked a separation between their symptoms and their self. There were several occasions where participants invoked a conceptualisation of "myself" that was separate to the thoughts and feelings associated with symptoms. For instance, when asked what was different about the times when Jennifer did not have

negative thoughts, she responded, “I’m happy, and... yeah I’m just, more myself.” Such thoughts and feelings are not only separate from one’s true self, but can disrupt one’s ability to fully *be* this known version of “myself”. This suggests that such symptoms may not necessarily become incorporated into a new idea of oneself; that is, what comprises “me” is not changed, but is interrupted.

At some points this lack of integration seemed to prompt a dual identity, in which there is a real self and another self that is beyond control. Jennifer, for instance, talked about how she did not “listen to myself” or believe in herself. In these instances, Jennifer had stepped outside of her *real* self and into a second self that is unreasonable and refuses to respond to what her original self is asking of it. It cannot listen or believe her and is driven by these apparently irrational thoughts. Similarly, Grace talked about an occasion where she had attempted to hide her feelings so as not to appear vulnerable, but explained “I didn’t, (sigh), I tried not, to let the bullies... see that I was crying, but I, I couldn’t help myself.” Here, Grace also makes use of a second, more rational self that is able to assess the situation and attempt to retain control, but the other “myself” invoked here is less restrained and cannot be controlled. Thus, it appears that for these participants the experience of these symptoms can create an internal divide, in which there is another self with a healthier and acceptable set of actions and beliefs, and a second, more unreasonable, self that is ruled by these symptoms and gives unwanted responses.

Discussion

Using IPA, we explored the ways that three at-risk early adolescent girls experienced and made sense of their emotional symptoms. This approach is advantageous as it offers insight into emotional symptoms among early adolescent girls from the perspective of those experiencing them, thus facilitating greater understanding and contributing to the development of appropriate support and provision. Our findings indicate that the thoughts and feelings associated with emotional symptoms can be dominant and overwhelming for adolescent girls, and can give rise to internal tensions and conflicts as they seek to make sense, or indeed strive to avoid making sense, of them.

Participants’ differing conceptualisations of the thoughts and feelings associated with symptoms appear to reflect both the affective and cognitive impairments generally considered central to both depressive and anxious symptomatology and disorder. That is, both depressive and anxious symptoms can be affective (e.g., feelings of sadness and fear), cognitive (e.g., negative thought patterns and information processing biases), and somatic (i.e., bodily alterations such as fatigue, headaches, and stiffness (33–37)). Thus, participants here focused more on particular types of symptomatology in their accounts. Such distinctions may reflect differing manifestations of particular symptoms; that is, Amelia and Jennifer appeared to experience more prominent cognitive symptoms than Grace, who predominantly presented with affective difficulties. However, it could also be that this reflects different ways of conceptualising one’s symptoms, with a focus on either feelings or thoughts simply representing different ways of understanding difficulties.

Amelia and Jennifer talked about “worries” and “negative thoughts” giving a sense that they saw them not only as thoughts but as objects that can be had and even given away. This focus on cognition may not necessarily be reflective of predominantly cognitive symptomatology, but instead may act as a way to rationalise or maintain control over difficult thoughts *and* feelings. Previous qualitative studies have found that adolescents experiencing depressive and anxious symptoms can find them confusing and difficult to control (18, 19, 21, 22, 24). Externalisation and objectification of feelings as tangible objects separate from the self may reflect a lack of control or, conversely, could represent psychological attempts to *retain* control. Indeed, such externalization of one’s difficulties is a key component of some therapeutic approaches, such as the narrative approach, as a way to separate these issues from the self and allow them to be interrogated without self-alienation (38). On the other hand, other therapeutic approaches might conceptualise the objectifying and externalising of feelings as a psychological defence, which operates to protect the sense of self. This psychological process may provide temporary solace and protection for the individual and thus serve a crucial protective function, but may ultimately represent a hindrance to development. It may be valuable for therapists to note where a patient appears to be objectifying and externalising painful feelings, so that the therapist may provide support in becoming more comfortable with these aspects, and ultimately give the potential for greater integration of selfhood, and self-acceptance.

The intensity and centrality with which participants were experiencing these thoughts and feelings suggest that emotional symptoms can act as a central and potentially overwhelming part of one’s inner life. Conceptualisations of both singular and collective thoughts and feelings suggests that such difficulties are more than simply a low mood or heightened state of anxiety, but are instead seen as comprising different points of concern and distress that operated together to overwhelm the self. This echoes previous qualitative findings; Weitkamp et al. (24) reported that adolescents experienced depression as a deeply overwhelming experience, while Woodgate (20) described how their adolescent participants presented depression as a multitude of varied but intense “bad feelings” (p. 264). Taken together, such findings show how intensely such difficulties can be experienced and demonstrates that this can be felt to exceed one’s coping capacities. Indeed, this manifestation of symptoms as overwhelming may explain why for some, these thoughts and feelings came to dominate their wider emotional landscape, with even positive emotions coming to be defined in this way for some. This reflects a recognition that emotional symptoms and disorders are defined not only by the *presence* of depressive and/or anxious feelings and thoughts, but also by their ability to intrude upon and limit wider areas of emotion and cognition (39). Indications that emotional symptoms can be a pervasive and central in one’s day-to-day life demonstrate an ethical need for appropriate prevention and support for adolescent girls, given indications of a recent increase in such difficulties (8).

That participants felt little control over the occurrence of symptoms is perhaps unsurprising, given that emotion appears to occur first within the brain, independently of cognitive processes, and is *then* felt, interpreted, and regulated (40, 41). That is, humans cannot control the arrival of an emotion, but may be able to cognitively modify and manage it. However, it may be that perceived loss of control when observing the occurrence of these symptoms is compounded when one struggles to make causal

attributions for them. Here, Amelia and Jennifer expressed difficulty in understanding where these symptoms came from, often expressing a lack of “knowing”. This perhaps links to the above point about externalising and objectifying emotions, as if they have wandered into these young people’s experiences in a random and uninvited way, without a link to the past, emotional experience or sense of self (42). Past qualitative studies have reported similar findings, with some adolescents voicing a sense of bewilderment and confusion about where these types of symptoms have come from (18, 19, 21, 22). Indeed, Midgley et al. (18) reflected that confusion regarding the occurrence of symptoms may represent a feature or symptom of depression, perhaps especially for adolescent populations, in its own right. Understanding emotional difficulties in the context of the patient’s life history, and helping the patients understand these links is of course a crucial therapeutic endeavour.

Indications that participants found it difficult to effectively regulate and respond to these feelings independently may suggest low emotional self-efficacy, which pertains to how confident individuals are in relation to their emotional abilities (43–45). Research indicates that lowered emotional self-efficacy is associated with depressive and anxious symptoms among children and adolescents (44, 46–49). It is perhaps unsurprising from a developmental perspective, however, that individuals of this young age may feel unequipped to deal with the difficult thoughts and feelings encapsulated within emotional symptoms. Indeed, qualitative studies have indicated a perceived loss of emotional control among adolescents experiencing emotional symptomatology (18, 19, 21, 22), while some authors have noted that feeling that one has active coping strategies to manage these feelings can facilitate greater perceived control (19, 22). Thus, findings suggest that emotional symptoms can be perceived as exceeding one’s perceived emotional capacity and it may be important to bolster both regulation skills *and* belief in such abilities, with perhaps greater emphasis on external support among younger adolescents who may find such intense feelings difficult to cope with alone.

Lack of control was also part of a wider sense that participants had not reconciled these symptoms with their identity. This is notable given participants’ age, where identity is generally considered to shift and change as young people engage in personal and social experimentation (50, 51). Given that many mental health disorders have their first onset in adolescence (52), it seems important to explore and understand how symptoms and difficulties may interact with developing identity constructions. It has been suggested that mental health disorders can clash with adolescent identity constructions (53–55), perhaps reflecting psychodynamic defence mechanism of *splitting of the ego*, or difficulty unifying different parts of oneself into a coherent whole (56, 57). This separation could represent a loss of control or could reflect a protective act, preserving a primary construction of oneself as happy and rational, rather than defined by more challenging thoughts and feelings and the actions they lead to. Indeed, research has identified instances of young people who over time have come to see symptoms and disorders as a central component of their identity, perhaps to hold onto a sense of stability for those experiencing turbulence in adolescence (23, 58). From a therapeutic perspective, Midgley et al. (18) have suggested that empowering young people to explore the meaning of their experiences and symptoms may offer greater feelings of control and order and, in turn, help them in re-establishing a sense of identity.

Strengths And Limitations

Use of IPA facilitated an in-depth exploration of how early adolescent girls experience and make sense of symptoms, including how they sit within one's emotional and personal landscape. This emphasis on subjective experience is an important and timely contribution given indications of growing rates of emotional symptoms among adolescent girls. There is an ethical need for researchers to build a well-rounded understanding of this phenomenon, including the subjective realities of how such symptoms are experienced and managed by those dealing with them. Indeed, findings highlight the need for further research exploring how symptoms affect subjective wellbeing and quality of life among adolescent girls, given the level of regularity and intensity with which such difficulties appeared to arise within participants' lives and the challenges raised around identity and control.

It should be noted that data was gathered within a wider project and so some phenomena were not always directly probed in interviews. In particular, participants were not asked whether being a girl was meaningful to them in these particular areas of their lives, and so it was not possible to explore whether they consider these experiences to be gendered. Future research could explore adolescent perspectives on the influence of gender in mental health experiences, which may provide further insight into why early adolescence appears to be a particularly vulnerable time for girls. It should also be noted that participants were selected for inclusion in HeadStart interviews by school staff, who may have been biased towards selecting particular types of individuals. For instance, young people considered more articulate may have been prioritised given use of a spoken interview, potentially overlooking those with language barriers.

Conclusions

The current study contributes to our understanding of how early adolescent girls experience and make sense of their emotional symptoms. We found that they experience emotional symptoms as an intense and at times unmanageable collection of intrusive thoughts and feelings, which can be difficult to align with existing constructions of their identity. Our exploration of subjective lived experience illuminates how intense these symptoms can be for adolescent girls, and suggests that there could be therapeutic value in supporting this group in exploring and making sense of their difficulties.

Abbreviations

IPA
Interpretative Phenomenological Analysis

Declarations

Ethics Approval and Consent to Participate

Ethics approval was granted by the University College London Research Ethics Committee (Ref. 7963/002). Written consent for participation was obtained from participants and from their

parents/carers.

Consent for Publication

Written consent included consent for publication of findings.

Availability of Data and Materials

Research data are not shared due to the personal nature of accounts and in line with the consenting procedure.

Competing Interests

The authors declare that they have no competing interests.

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Authors' Contributions

OD led the study, including design, analysis, and manuscript writing; NH provided supervision throughout and supported in manuscript drafting; JH provided expert practitioner input and supported in manuscript drafting.

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