

Christian Jonathan Haverkamp

Social Media, Mood, and Self-Image: A Critical Review of Screen-Time Research

Narrative Literature Review

Abstract—Public debate often treats 'screen time' as a single exposure with a simple dose-response relationship to adolescent mental health. Evidence available through 30 May 2024 does not support that simplification. Associations between broad duration measures of digital technology use and well-being are generally small at the population level, sensitive to measurement and analytic choices, and insufficient to establish causation. Social media may support friendship, identity exploration, information, and community while also intensifying appearance comparison, cyberbullying, sleep disruption, repeated checking, and harmful content. This narrative review examines cross-sectional and longitudinal evidence, individual susceptibility, body image, quantified feedback, cyberbullying, sleep, and bidirectional pathways. It proposes a person-platform-context formulation in which the clinically relevant unit is a specific digital episode: its antecedents, activity and content, interpersonal meaning, displaced alternatives, and immediate and delayed consequences. Population averages and event-level harms answer different questions. Restriction may be warranted for defined risks, but indiscriminate restriction can remove valued support or leave the underlying problem untouched. Assessment and intervention should therefore target the demonstrated mechanism. The clinical aim is not lower use for its own sake, but greater safety, agency, sleep, connection, and participation.

Index Terms—social media, screen time, adolescent mental health, clinical formulation, depression, anxiety, body image, cyberbullying, sleep

I. INTRODUCTION

A phone can provide friendship, schoolwork, news, appearance comparison, harassment, crisis support, entertainment, and an alarm clock. Grouping these activities as 'screen time' makes them easier to count but harder to understand. The same hour may strengthen one adolescent's connection and deepen another's shame; clinically, the difference lies in activity, content, relationship, design, vulnerability, timing, and what the activity displaced.

Earlier JPPC articles on social anxiety, depression, and communication have emphasized the meanings attached to interpersonal feedback (Haverkamp, 2013; Haverkamp, 2017a; Haverkamp, 2017b). Social platforms can make such feedback continuous, quantified, searchable, and portable. This review therefore distinguishes population-level association from clinically meaningful pathways of benefit or harm.

II. SCOPE AND REVIEW METHOD

This narrative review covers literature available through 30 May 2024. Searches addressed digital technology and adolescent well-being; social networking and depression or anxiety; longitudinal evidence; body image; cyberbullying; screen-time measurement; sleep; individual differences; and professional guidance. Priority was given to professional guidance, systematic and umbrella reviews, meta-analyses, longitudinal studies, diagnostic research, and clinically informative original studies. Bibliographic details were checked against PubMed, Crossref, or the issuing organization's record. JPPC articles were included only when they materially informed the clinical formulation.

No pooled effect estimate or formal risk-of-bias assessment was undertaken. The review's clinical purpose is to support individual assessment and shared formulation. It uses a person-platform-context formulation that traces antecedents, activity and content, interpersonal meaning, immediate and delayed consequences, and displaced alternatives. Population averages should not substitute for the person's history, context, and current risk.

Unless otherwise stated, all tables and boxed frameworks in this article are author-developed clinical syntheses intended to organize assessment and discussion; they are not validated instruments or substitutes for clinical judgment.

Christian Jonathan Haverkamp, M.D., LL.M., is a psychotherapist working in private practice in Dublin, Ireland. Correspondence: jonathanhaverkamp@gmail.com. Website: www.jonathanhaverkamp.com. © 2024 Christian Jonathan Haverkamp.

Clinical propositions

- A screen-time total conceals activity, content, purpose, context, timing, control, and displacement.
- Broad duration measures usually show small average associations and often leave direction uncertain.
- Small averages can coexist with severe event-level harm and marked effects in susceptible individuals.
- Comparison, cyberbullying, sleep disruption, checking, and avoidance are distinct mechanisms.
- Preserve beneficial connection and target the demonstrated mechanism; restriction is not a neutral default.

III. WHAT THE EVIDENCE CAN AND CANNOT SAY

Cross-sectional studies show whether heavier use and worse mood occur together; they cannot determine which came first. Depression may lead an adolescent to spend more time online, shift toward passive browsing, or interpret ambiguous feedback more negatively. Loneliness, bullying, family conflict, and sleep disruption may influence both use and mood. Self-reported duration is also imprecise and often captures a typical day rather than the particular episode that matters clinically.

Using large datasets and specification-curve analysis, Orben and Przybylski (2019) found small associations between digital technology use and adolescent well-being that varied with analytic choices. Jensen et al. (2019), combining longitudinal and daily-report methods, found little evidence that adolescents' digital use predicted subsequent mental-health symptoms within individuals. These findings do not establish that digital use is harmless; they make a large, uniform causal effect less plausible.

Reviews and consensus reports likewise emphasize modest average associations, measurement limitations, reciprocal pathways, and substantial heterogeneity in who is affected, by which feature, and under what conditions (National Academies of Sciences, Engineering, and Medicine, 2024; Odgers & Jensen, 2020; Valkenburg et al., 2022). Population averages and event-level harms answer different questions: a small mean association can coexist with severe harassment, exploitation, or sleep loss in a particular case. Clinical assessment must therefore reconstruct the person's sequence; an average effect size cannot determine individual risk.

Dimensions obscured by a screen-time total

Dimension	Examples
Activity	Messaging, browsing, posting, gaming, learning, creating
Content	Friends, appearance ideals, self-harm or suicide content, news, support, harassment

Dimension	Examples
Social context	Known peers, strangers, group chats, private messages, public engagement metrics
Purpose	Connection, expression, information, reassurance, avoidance, boredom
Timing, displacement, and control	Before sleep or after conflict; what is displaced; whether use is intentional, interruptible, cue-driven, or difficult to stop

IV. SMALL AVERAGES, UNEQUAL EFFECTS

A small average association may mean that most effects are small, that benefits and harms offset one another, or that a minority experiences larger changes. Susceptibility may reflect depression or anxiety, social exclusion, body-image concerns, neurodevelopmental differences, sleep vulnerability, identity-related stigma, or harmful networks. Platforms and cultural practices also change faster than many research cycles.

The Goldilocks hypothesis suggested that moderate digital engagement might be compatible with, or weakly associated with, better well-being than very low or very high use (Przybylski & Weinstein, 2017). It does not supply a universal hourly threshold. The observed curves remain vulnerable to confounding, and 'moderate' use has different meanings across activities, developmental stages, and individuals.

Clinical significance is better located at the level of events and mechanisms than minutes. An extra 20 minutes of routine use may matter little; a humiliating post circulated among classmates may precipitate acute distress. An identity-affirming community may reduce isolation, whereas appearance-focused content may intensify comparison. Duration matters, but it does not identify the pathway of benefit or harm.

V. MOOD, CONNECTION, AND DIRECTION OF EFFECT

Seabrook et al. (2016) found mixed associations between social networking sites, depression, and anxiety, shaped by comparison, interaction quality, and individual differences. Adolescent reviews likewise report heterogeneous exposure measures, outcome definitions, and predominantly observational designs (Keles et al., 2020; Vidal et al., 2020). The literature supports an association more readily than it supports the claim that social media causes depression.

Active, reciprocal communication may support belonging, whereas passive consumption may invite comparison, but this distinction is not reliably predictive. Messaging can become

reassurance seeking; browsing can provide education, identity support, or community. The useful distinction is functional: does the activity increase connection and agency, or leave the person isolated, threatened, preoccupied, or unable to disengage?

Bidirectionality changes the interview. Sadness may prompt scrolling, rejection may prompt repeated posting or checking, and anxiety may prompt monitoring for exclusion. Removing the device may then suppress a coping behavior without addressing the loneliness, threat, or uncertainty that drives it. Adolescent depression cannot be inferred from platform use; assessment should establish symptoms, course, impairment, family and school context, and safety (Cheung et al., 2018; Thapar et al., 2012; Zuckerbrot et al., 2018).

Examples of bidirectional digital-use sequences

Before	Digital action	Immediate outcome	Later outcome
Loneliness	Message a trusted friend	Connection	Potential support
Loneliness	Browse idealized portrayals	Distraction	Comparison and isolation
Appearance worry	Post and check likes	Brief reassurance	Greater dependence on metrics
Conflict	Monitor another person's status	Uncertainty briefly falls	Checking and mistrust grow
Low mood	Seek peer recovery content	Validation	Helpful or harmful, depending on content
Boredom at night	Autoplay and notifications	Stimulation	Sleep opportunity reduced

VI. SELF-IMAGE, APPEARANCE, AND QUANTIFIED FEEDBACK

Social platforms expose users to curated images, image editing, appearance commentary, and publicly visible metrics. A systematic review linked social-networking-site use with body-image and disordered-eating concerns, while noting that most included studies were cross-sectional (Holland & Tiggemann, 2016). Social comparison and appearance-focused use are plausible pathways rather than consequences of duration alone (Fardouly & Vartanian, 2016).

Self-presentation is not inherently deceptive; every social setting involves selection. Difficulty may arise when the edited public self becomes the standard against which ordinary private experience is judged, or when likes and other metrics are treated as evidence of personal worth. Repeated retaking,

deletion, posting, and checking may then operate as appearance-related safety behaviors: they relieve uncertainty briefly while strengthening dependence on external confirmation.

Assessment should identify content and sequence before attributing an appearance effect. Which feeds inform or connect, and which reliably evoke shame or comparison? Selective muting or curation can be framed as a monitored behavioral experiment, with effects on mood, checking, and participation reviewed over time. Self-compassion may help address shame and global self-criticism, but evidence for the construct does not show that it neutralizes harmful content or treats an eating disorder (MacBeth & Gumley, 2012; Neff, 2003).

VII. CYBERBULLYING, HARASSMENT, AND SAFETY

Cyberbullying is not simply a high-dose form of social media use. It may be persistent, public, searchable, anonymous, and difficult to escape when the same channels also carry friendship and school communication. Population research associates involvement in cyberbullying with poorer adolescent well-being, although adjusted effects may be small and cross-sectional data cannot establish causal sequence (Przybylski & Bowes, 2017). A disclosure of harassment calls for a proportionate safety and safeguarding response, not a generic reduction in screen time.

When safe, threats and harmful content should be documented and evidence preserved according to local guidance. Blocking, reporting, school or caregiver involvement, safeguarding services, or law enforcement may be appropriate depending on severity and jurisdiction; disclosure or confrontation may sometimes increase risk. Sexual imagery that may involve a person under 18 should not be downloaded, copied, or forwarded unless instructed by the appropriate safeguarding or law-enforcement authority under applicable local law. Preserve non-image identifiers when it is safe to do so and follow local safeguarding or police guidance. Identity-based harassment, sexual exploitation, coercive control, and nonconsensual intimate-image sharing require specific pathways.

Leaving a platform may reduce exposure, but it may also cut the targeted person off from friends, school information, or a valued community. Safety planning should therefore preserve alternative routes to connection and should not place responsibility for ending abuse on the person who was harmed.

VIII. SLEEP, ATTENTION, AND DISPLACEMENT

Night-time device use can delay bedtime, interrupt sleep through notifications, and sustain cognitive or emotional arousal. The relevant pathways extend beyond light exposure to bedtime displacement, activating content, social obligation, and reciprocal use when sleep is already poor. Sleep loss may then worsen mood, concentration, and emotion regulation, creating a cycle in which the device is used for relief but becomes harder to put down on subsequent nights (American Psychological Association, 2023; Office of the Surgeon General, 2023).

Displacement is a testable clinical hypothesis, not an assumption. If digital use replaces sleep, exercise, face-to-face contact, study, meals, treatment tasks, or quiet recovery, the cost can be observed. Yet online activity may also replace isolation, facilitate disability access, or provide otherwise unavailable support. Before recommending restriction, the assessor should ask what is likely to occupy the released time and whether that alternative is realistically available.

Illustrative, author-developed monitored trials may include silencing notifications, charging the device outside the sleeping area, protecting a wind-down period, scheduling checks, or moving a valued conversation to a less interruptive channel. Outcomes should include sleep onset, awakenings, next-day function, mood, urge, connection, and participation, not minutes alone. When late-night use and insomnia co-occur, insomnia warrants age-appropriate assessment and evidence-based treatment in its own right.

Mechanism-matched intervention trials

Maintaining process	Targeted trial	Outcome
Night-time interruption	Silence notifications; keep the device outside the sleeping area	Sleep onset, awakenings, next-day function
Appearance comparison	Mute selected feeds; add diverse or neutral content	Mood and body-image preoccupation
Reassurance checking	Schedule checks and observe the urge	Urge duration and relationship functioning
Harassment	Safeguarding plan and safe evidence preservation	Exposure, safety, available support
Avoidance	Complete one valued offline action before browsing	Participation and mood
Isolation	Initiate purposeful reciprocal contact	Belonging and available support

IX. FAMILY AND CLINICAL CONVERSATIONS

Household boundaries are more workable when they serve a defined aim, are discussed with the young person, and are followed consistently by adults. A collaborative plan can specify sleep protection, school requirements, privacy, safety, and exceptions. Professional guidance favors developmentally appropriate boundaries with ongoing conversation and coaching rather than time limits alone (American Psychological Association, 2023; National Academies of Sciences, Engineering, and Medicine, 2024; Office of the Surgeon General, 2023). Monitoring technology raises separate questions about trust, privacy, and safeguarding and should not replace communication.

Online life belongs in routine psychosocial assessment, but the inquiry should not begin with an assumption of misuse. Clinicians can ask who matters online, what happens after posting, which communities support identity or recovery, and whether the person encounters self-harm methods, extremist recruitment, financial exploitation, sexual coercion, or eating-disorder content. Direct questions are most useful when they are specific, nonjudgmental, and proportionate to the presenting concern.

A communication-focused perspective examines how platform design changes interpersonal signals: a delayed reply may be read as rejection, popularity is quantified, tone is harder to infer, and separate audiences can collapse into one. Earlier JPPC work on social anxiety emphasized the meanings attached to evaluation and connection (Haverkamp, 2013; Haverkamp, 2017b). Therapy can examine these interpretations while also altering the digital conditions that repeatedly evoke them.

X. CONTEXT, EQUITY, AND ACCESS

Clinical interpretation depends on social and cultural context. Opportunity, power, language, disability, service design, and prior treatment shape both experience and the evidence available to the assessor. Equity requires rigorous criteria together with better contextual evidence and care not to recast structural constraint as individual pathology (National Academies of Sciences, Engineering, and Medicine, 2024; Office of the Surgeon General, 2023).

For marginalized adolescents, online communities may provide belonging unavailable or unsafe locally. Restriction can therefore remove protection as well as exposure. Assessment should identify the language, identity support, or connection the platform provides, whether a safer alternative

exists, and who can help secure it. Outcomes should be judged against options the person can actually access.

Schoolwork, health care, employment, and social participation may require digital access, so blanket abstinence can deepen exclusion. Separate the harmful activity from needed access, then identify workable boundaries, alternative routes, and who can provide them. Removing essential access is not a valid test of self-control or treatment engagement.

Recommendation systems, commercial incentives, notifications, and other platform features shape exposure. Responsibility cannot therefore rest on individual self-control alone. Formulation should distinguish choices available to the young person from conditions controlled by platforms, institutions, or caregivers, and target the demonstrated pathway of harm (National Academies of Sciences, Engineering, and Medicine, 2024; Office of the Surgeon General, 2023).

XI. PLATFORM DESIGN, CUEING, AND CONTROL

Platform design affects what is encountered and how easily a session ends. Infinite scroll, autoplay, notifications, intermittent social feedback, and personalized recommendations can extend use without showing that heavy use is itself an addiction. Clinically, these features justify asking whether use was intended, whether stopping attempts repeatedly failed, what cues restarted the sequence, and which valued activity was lost. Environmental changes can then test cueing and stopping friction without moralizing about willpower (National Academies of Sciences, Engineering, and Medicine, 2024; Office of the Surgeon General, 2023).

Quantified feedback can change the meaning of ordinary social uncertainty. Likes, view counts, streaks, public comments, and algorithmic ranking may be interpreted as measures of worth or belonging, while editing tools encourage repeated comparison between a curated public image and ordinary private experience. Assessment should establish the person's interpretation and sequence; the presence of a metric alone does not demonstrate harm. A monitored change such as hiding metrics, delaying posting, or altering followed accounts is informative only if the predicted effect on mood, checking, self-evaluation, or participation is specified in advance.

Design features also interact with interpersonal communication. A delayed response can be experienced as rejection, separate audiences may collapse into one, and a private conflict may become searchable or public. Reconstructing one episode—what was sent or seen, what meaning was assigned, what response was sought, and what happened next—often yields a more testable formulation than

debating whether the platform is good or bad. The same reconstruction should record any durable connection, information, creativity, or identity support that would be lost through restriction.

XII. IMPLEMENTING A COLLABORATIVE DIGITAL PLAN

A useful plan begins with one plausible mechanism and one defined outcome. The person and clinician can record a feasible baseline, select a change small enough to test, identify the expected benefit, and agree when to review it. Sleep opportunity, mood, checking, concentration, connection, participation, and exposure to harm may be more informative than total minutes. If the predicted change does not occur, the result should weaken the hypothesis; it should not automatically prompt broader restriction.

Potential adverse effects should be anticipated. Removing an application may interrupt friendship, crisis contact, school information, disability access, or an identity-affirming community; increased monitoring may reduce trust or drive disclosure underground. The plan should therefore name what useful function is being preserved, what alternative route will remain available, and which signs—worsening isolation, concealment, escalating conflict, or loss of support—would prompt revision. Restriction is an intervention with possible burden, not a neutral control condition.

For adolescents, roles and confidentiality should be stated explicitly. The young person should understand the purpose of a boundary, what information caregivers or services may receive, and what choices remain. Caregivers can describe observable concerns and implement proportionate household limits, while the clinician protects space for disclosure within legal and safeguarding duties. Clear communication is itself a safety measure because a person who anticipates automatic punishment or loss of all access may be less likely to report harassment, coercion, or self-harm content (American Psychological Association, 2023; National Academies of Sciences, Engineering, and Medicine, 2024).

A written review can distinguish routine difficulty from escalation. Ordinary urges or frustration may be monitored within the agreed trial; credible threats, exploitation, sexual coercion, imminent self-harm, severe eating-disorder deterioration, psychosis, mania, or inability to maintain basic safety require the appropriate urgent psychiatric, medical, safeguarding, emergency, or legal pathway. Platform reporting and device controls may support a response but do not replace clinical or safeguarding assessment.

XIII. INDIVIDUAL DIFFERENCES, DEVELOPMENT, AND DIFFERENTIAL FORMULATION

Population estimates should be transferred to an individual only after comparing developmental stage, baseline symptoms, activity, content, social context, timing, and outcome. Adolescence includes rapid changes in autonomy, peer relationships, identity, sleep, and access to support, while the platforms and practices studied also change. A small average association may therefore be a poor estimate for a particular person in a particular week. The defensible clinical question is not whether social media has one average effect, but whether a specified pattern preceded or followed a meaningful change in this person's safety, symptoms, or functioning (National Academies of Sciences, Engineering, and Medicine, 2024; Odgers & Jensen, 2020; Valkenburg et al., 2022).

Chronology helps distinguish several roles. Digital activity may be a precipitant, a maintaining process, a response to distress, a source of protection, or largely incidental to the presenting problem. Low mood may precede passive comparison; social exclusion may drive repeated checking; poor sleep may increase night-time use; or an online community may reduce isolation while another part of use is harmful. More than one role can be present. The formulation should state each proposed sequence separately and identify what observation would strengthen or weaken it rather than assigning a single global cause.

Differential assessment remains necessary when symptoms are substantial. Persistent depression, social anxiety, trauma-related symptoms, eating-disorder behavior, attention or neurodevelopmental difficulties, substance use, insomnia, mania, psychosis, family violence, or exploitation should be evaluated on their own clinical merits. A digital-use intervention is not an adequate substitute for assessment or evidence-based treatment of an established disorder, and treatment should not be delayed until the direction of a screen-time association is settled (Cheung et al., 2018; Thapar et al., 2012; Zuckerbrot et al., 2018).

The role assigned to digital use should be revised over time. If symptoms improve when the proposed mechanism changes, the result supports but does not prove that formulation because other conditions may have changed simultaneously. If symptoms persist, examine adherence and exposure to the target before broadening restriction, then reconsider diagnosis, stressors, relationships, sleep, treatment access, and beneficial online functions. If the intervention worsens isolation or removes a protective relationship, reverse or modify it promptly unless an overriding safety requirement applies.

XIV. FROM AN INDIVIDUAL PLAN TO A SYSTEM RESPONSE

Many digital harms are interpersonal or institutional rather than failures of individual self-control. A school may need to address peer conduct, a platform may need to restrict an account or preserve a report, caregivers may need to provide a safe contact route, and clinical or safeguarding services may need to coordinate a response. Each participant should have a defined task and boundary. The young person should not be asked to negotiate directly with an alleged perpetrator, surrender all connection, or carry responsibility for stopping abuse by leaving a valued community.

Coordination should preserve confidentiality as far as safety and law allow. Record what information is needed, why it is needed, who may receive it, and what the person understands about the plan. When reports differ, document the source and opportunity to observe rather than converting disagreement into a credibility judgment without inquiry. Communication with families and schools is most useful when it concerns observable events, agreed support, and reviewable limits rather than diagnostic labels or unrestricted access to private clinical material.

Equity changes the available response. Advice to leave a platform is not equivalent when it is the person's main route to language, disability access, minority support, education, health care, or friendship. A proportionate plan separates the harmful channel or behavior from essential access and identifies a realistic replacement before removing support. Outcomes should include whether the person is safer and more able to participate, not simply whether a device rule was followed (American Psychological Association, 2023; National Academies of Sciences, Engineering, and Medicine, 2024; Office of the Surgeon General, 2023).

XV. MEASUREMENT, FOLLOW-UP, AND REVISION

Before changing digital use, define the outcome, interval, observer, and threshold for meaningful change. Symptom measures and device logs may help, but should be interpreted alongside function, safety, adverse effects, and the person's priorities. Establish a feasible baseline. If the result does not fit the proposed mechanism, revise the formulation rather than escalate automatically to broader restriction.

Track sleep opportunity, bedtime delay, night interruption, and next-day recovery across ordinary routines. Compare mood and self-evaluation before and after defined activities such as messaging, posting, browsing, or appearance-focused viewing. Record immediate relief as well as later connection, shame, conflict, impaired concentration, and loss of intended

activity. Device logs quantify exposure; they do not explain purpose or meaning.

Monitor comparison, harassment, coercion, self-harm content, exploitation, and privacy breaches alongside supportive contact and identity-affirming community. Review whether online and offline participation expands or contracts, what was displaced, and whether the targeted trial produced the predicted change. Deterioration, loss of useful support, or no meaningful effect should prompt reconsideration of the sequence, diagnosis, implementation, and level of care.

Outcome domains for follow-up

Domain	Outcomes
Symptoms and course	Sleep opportunity, night interruption, mood
Behavior and function	Self-evaluation before and after defined activities
Control and exposure	Checking frequency, urgency, and ability to delay
Relationships and safety	Reciprocal connection; comparison, harassment, harmful content
Formulation and treatment	Predicted change, adverse effects, loss of useful support

XVI. CLINICAL INTERVIEW DOMAINS

Begin with activity and function rather than a daily total. For a recent episode and a typical week, establish what happened, what preceded it, what the person hoped to gain or avoid, and what changed immediately and later. Distinguish connection, information, comparison, reassurance, conflict, harassment, checking, and sleep displacement. Assess benefits and harms together.

These domains should guide, not script, the interview. Inquiry should proceed at a pace appropriate to development, capacity, consent, privacy, safety, and the clinical setting. When collateral information may be useful, explain its purpose and limits, seek consent where appropriate, observe confidentiality and safeguarding duties, and record the informant's relationship to the person and opportunity to observe.

Reconstruct activity, content, and sequence as specifically as possible. Distinguish messaging, browsing, posting, gaming, learning, creating, and monitoring another person; identify the material encountered rather than infer it from duration. Establish the antecedent, immediate effect, and later consequence. Comparison with a different episode can help identify the maintaining mechanism.

Social function, control, and displacement require separate questions. Ask who matters, what response was sought or feared, how silence or metrics were interpreted, whether use can be interrupted, and what happens when checking is delayed. Identify what the activity replaces without assuming offline time is healthier; digital use may displace sleep, but also provide accessibility, education, or community.

Ask directly about bullying, threats, coercion, stalking, sexual exploitation, nonconsensual intimate images, self-harm or suicide content, identity-based harassment, and privacy breaches. Establish whether risk is current, who has access, what safe connection remains, and whether contacting a service could increase danger. Suicidal intent, imminent self-harm, credible threats, sexual exploitation, psychosis, mania, or inability to maintain basic safety require urgent local psychiatric, safeguarding, emergency, or legal assessment. Acute medical deterioration requires medical assessment and should not be subsumed under a digital-use formulation.

Person-platform-context assessment map

Domain	Questions to examine
Activity and content	What exactly happens on which platform or channel?
Sequence	What happened before use, immediately afterward, and later?
Social function	Connection, comparison, conflict, reassurance, identity, support?
Control	Can the activity be interrupted? What happens when checking is delayed?
Displacement	Sleep, study or work, movement, meals, treatment, relationships?
Harm	Bullying, coercion, self-harm or suicide content, exploitation, privacy breach?
Protection	Trusted contacts, reporting routes, alternative connection, family agreement?

XVII. LIMITATIONS AND RESEARCH NEEDS

This is a narrative rather than a systematic review. Source selection was purposive, and no formal risk-of-bias assessment or meta-analysis was undertaken; the conclusions are therefore a clinical synthesis, not pooled estimates. Systematic and umbrella reviews reduce selective citation, but they inherit the definitions, measurement limitations, and biases of their source studies.

Both exposure and outcome require precise definition. Self-reported screen time, device logs, platform activity, specific content, diagnoses, questionnaire scores, behavioral records,

and administrative outcomes are not interchangeable. Clinical samples remain underrepresented. Conversely, very large datasets can make small associations appear decisive, while group means can obscure clinically important event-level benefit or harm.

Causal language should match study design. Cross-sectional association cannot establish whether digital use or mood changed first. Longitudinal studies improve temporal ordering but retain confounding and measurement error. Randomized studies support causal claims about the tested intervention under its trial conditions; they do not establish every proposed platform mechanism or predict every individual response.

Platform features, norms, and regulatory conditions change quickly. Because the literature cutoff was 30 May 2024, this review does not incorporate later evidence, policy changes, safety warnings, or platform developments. Clinical use should therefore be accompanied by a check for updated guidance, retractions, and newer comparative evidence.

Future research should measure content, purpose, relationship context, sequence, sleep, control, and functional consequences rather than duration alone. More within-person and longitudinal designs should include clinical and marginalized populations, distinguish durable connection from short-lived reassurance, report adverse effects, and test whether mechanism-matched changes improve outcomes beyond simple time reduction.

XVIII. CONCLUSION

Screen time is too coarse to explain adolescent mood or self-image. This review proposes a person-platform-context formulation in which the clinically relevant unit is a defined digital episode: its antecedents, activity and content, interpersonal meaning, immediate reinforcement, delayed consequences, and displaced alternatives. Population averages and event-level harms are not competing truths: small mean associations can coexist with substantial effects from comparison, harassment, sleep disruption, repeated checking, or harmful content in susceptible individuals.

The practical implication is mechanism matching. Preserve beneficial connection, identify the pathway maintaining distress, and treat restriction as a monitored intervention with potential adverse effects rather than a neutral default. Success is shown not by fewer minutes alone, but by improved safety, agency, sleep, reciprocal connection, and valued participation. This shift from counting time to testing function offers a firmer basis for clinical decisions and future research.

XIX. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT), which informs the communication-oriented formulation discussed in this review. CFT is not presented as a substitute for established diagnostic assessment, evidence-based treatment, or independent replication. The author reports no other conflicts of interest.

Funding—The author received no specific funding for this work.

Author contributions—Christian Jonathan Haverkamp is the sole author and is responsible for the conception, literature review, manuscript preparation, and approval of the final manuscript.

Patient material—No identifiable patient material is presented. All examples are hypothetical and were created solely to illustrate clinical reasoning; they are not case reports.

XX. REFERENCES

- American Psychological Association. (2023). Health advisory on social media use in adolescence. <https://www.apa.org/topics/social-media-internet/health-advisory-adolescent-social-media-use>
- Cheung, A. H., Zuckerbrot, R. A., Jensen, P. S., Laraque, D., Stein, R. E. K., & GLAD-PC Steering Group. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and ongoing management. *Pediatrics*, 141(3), e20174082. <https://doi.org/10.1542/peds.2017-4082>
- Fardouly, J., & Vartanian, L. R. (2016). Social media and body image concerns: Current research and future directions. *Current Opinion in Psychology*, 9, 1–5. <https://doi.org/10.1016/j.copsyc.2015.09.005>
- Haverkamp, C. J. (2013). A case of social anxiety. *J Psychiatry Psychotherapy Communication*, 2(1), 14–20.
- Haverkamp, C. J. (2017a). Communication-Focused Therapy (CFT) for depression. *J Psychiatry Psychotherapy Communication*, 6(4), 101–104.
- Haverkamp, C. J. (2017b). Communication-Focused Therapy (CFT) for social anxiety and shyness. *J Psychiatry Psychotherapy Communication*, 6(4), 108–113.
- Holland, G., & Tiggemann, M. (2016). A systematic review of the impact of the use of social networking sites on body image and disordered eating outcomes. *Body Image*, 17, 100–110. <https://doi.org/10.1016/j.bodyim.2016.02.008>
- Jensen, M., George, M. J., Russell, M. R., & Odgers, C. L. (2019). Young adolescents' digital technology use and mental health symptoms: Little evidence of longitudinal or daily linkages. *Clinical Psychological Science*, 7(6), 1416–1433. <https://doi.org/10.1177/2167702619859336>
- Keles, B., McCrae, N., & Grealish, A. (2020). A systematic review: The influence of social media on depression, anxiety and psychological distress in adolescents. *International Journal of Adolescence and Youth*, 25(1), 79–93. <https://doi.org/10.1080/02673843.2019.1590851>
- MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, 32(6), 545–552. <https://doi.org/10.1016/j.cpr.2012.06.003>
- National Academies of Sciences, Engineering, and Medicine. (2024). Social media and adolescent health. The National Academies Press. <https://doi.org/10.17226/27396>

- Neff, K. D. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2(2), 85–101. <https://doi.org/10.1080/15298860309032>
- Odgers, C. L., & Jensen, M. R. (2020). Annual Research Review: Adolescent mental health in the digital age: Facts, fears, and future directions. *Journal of Child Psychology and Psychiatry*, 61(3), 336–348. <https://doi.org/10.1111/jcpp.13190>
- Office of the Surgeon General. (2023). Social media and youth mental health: The U.S. Surgeon General's advisory. U.S. Department of Health and Human Services. <https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf>
- Orben, A., & Przybylski, A. K. (2019). The association between adolescent well-being and digital technology use. *Nature Human Behaviour*, 3(2), 173–182. <https://doi.org/10.1038/s41562-018-0506-1>
- Przybylski, A. K., & Bowes, L. (2017). Cyberbullying and adolescent well-being in England: A population-based cross-sectional study. *The Lancet Child & Adolescent Health*, 1(1), 19–26. [https://doi.org/10.1016/S2352-4642\(17\)30011-1](https://doi.org/10.1016/S2352-4642(17)30011-1)
- Przybylski, A. K., & Weinstein, N. (2017). A large-scale test of the Goldilocks hypothesis. *Psychological Science*, 28(2), 204–215. <https://doi.org/10.1177/0956797616678438>
- Seabrook, E. M., Kern, M. L., & Rickard, N. S. (2016). Social networking sites, depression, and anxiety: A systematic review. *JMIR Mental Health*, 3(4), e50. <https://doi.org/10.2196/mental.5842>
- Thapar, A., Collishaw, S., Pine, D. S., & Thapar, A. K. (2012). Depression in adolescence. *The Lancet*, 379(9820), 1056–1067. [https://doi.org/10.1016/S0140-6736\(11\)60871-4](https://doi.org/10.1016/S0140-6736(11)60871-4)
- Valkenburg, P. M., Meier, A., & Beyens, I. (2022). Social media use and its impact on adolescent mental health: An umbrella review of the evidence. *Current Opinion in Psychology*, 44, 58–68. <https://doi.org/10.1016/j.copsyc.2021.08.017>
- Vidal, C., Lhaksampa, T., Miller, L., & Platt, R. (2020). Social media use and depression in adolescents: A scoping review. *International Review of Psychiatry*, 32(3), 235–253. <https://doi.org/10.1080/09540261.2020.1720623>
- Zuckerbrot, R. A., Cheung, A., Jensen, P. S., Stein, R. E. K., Laraque, D., & GLAD-PC Steering Group. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice preparation, identification, assessment, and initial management. *Pediatrics*, 141(3), e20174081. <https://doi.org/10.1542/peds.2017-4081>