

“I think this is maybe our Achilles heel...” exploring GPs’ responses to young people presenting with emotional distress in general practice: a qualitative study

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ABSTRACT

Objective: An exploratory study to investigate general practitioners’ (GPs’) views and experiences of consulting with young people (aged 12–19 years) presenting with emotional distress in general practice.

Design: A qualitative study using grounded theory and situational analysis. Empirical data were generated through in-depth interviews based on a topic guide developed from the literature, and augmented with a series of situational maps. Continuous field notes and theoretical memos were recorded during data collection and analysis.

The data were analysed using the constant comparative method of grounded theory. There were three levels of analysis. The first level developed the open codes and is presented here.

Setting: 18 general practices located in the north east of England. The practices recruited included rural, urban and mixed populations of patients who were predominantly living in socioeconomically disadvantaged communities.

Participants: 19 GPs (10 women) aged between 29 and 59 years participated. The modal age range was 40–49 years. Theoretical sampling was used to guide recruitment and continued until theoretical saturation was reached.

Results: The overarching finding was that anxiety about practice dominated clinical consultations involving young people presenting with emotional distress. GPs responded differently to anxiety and to related uncertainties about professional practice, independent of GP age or gender. Anxiety occurred in the consultation, at an external level, across disciplinary boundaries, in relation to communication with young people and secondary to the complexity of presentations.

Conclusions: Adolescent emotional distress presents professional challenges to GPs who feel ill-equipped and inadequately prepared to address early need. Medical education needs to prepare doctors better. More research is needed to look at what factors facilitate or prohibit greater GP engagement with emotionally distressed young people.

ARTICLE SUMMARY

Strengths and limitations of this study

- Qualitative research in underexamined areas offers new insights and explores how behaviours might arise.
- The data presented contributes to theory building.
- Theoretical sampling led to only white British-born GPs participating so other cultural perspectives were not included.

INTRODUCTION

Emotional distress in young people is common. It may be the affective response to the challenges of everyday life or may indicate a mental health disorder compatible with a psychiatric diagnosis. The most recent and widely cited household survey reports that at least 10% of 10 to 15-year-olds¹ and 17% of 16 to 19-year-olds² have symptoms consistent with a mental health disorder as defined by the International Classification of Diseases, 10th Revision (ICD-10). Behavioural manifestations of emotional distress might include self-harm, which at a conservative estimate appears to affect around 10% of adolescents, as reported in six studies cited by Hawton *et al*³ in a recently published review.

Data from populations of young people who consult their general practitioners (GPs) reveal higher rates of psychological distress of the order of 20–30%.^{4,5} GPs identify serious mental illness but often fail to detect less severe manifestations⁶ and appear reluctant to discuss emotional issues,⁷ unless they are offered cues by the young person in the consultation⁸ or there are other factors present, such as a history of a suicide attempt or a pattern of frequent consulting.⁹ Young

people's presentations in primary care are often complex and present with behavioural, psychosocial, academic and familial problems which can be problematic to untangle, in contrast to adult mental health manifestations, which, although variable, may be less intense in their presentation. Adolescent emotional distress may indicate underlying comorbid mental health problems and it has been suggested that often the 'most important features in terms of assessment may be concealed or hidden'.¹⁰ A key concern is the difficulty of distinguishing between 'moodiness' and a persisting emotional disorder, and GPs have expressed a worry at 'over-medicalising young people's lives'.¹¹ Iliffe and colleagues found that GPs were uncomfortable about making a diagnosis of depression in young people (the most common, but often coexisting, mental health problem in adolescence).

On the other hand, GPs are increasingly involved in managing common mental health problems in older patients.¹² Although a biomedical perspective dominates, supported by an array of National Institute for Health and Care Excellence (NICE) clinical guidelines, alternative frameworks for considering adult mental health problems have been offered. Dowrick¹³ and Reeve¹⁴ refer to the insights derived from the wisdom traditions in informing their work which moves away from a positivist understanding of emotional distress to an approach which incorporates ideas of personal agency and encourages hope.¹⁵ Historically, research has found GPs to be largely dismissive of their role in addressing social issues in adult mental ill health.¹⁶ Contemporary studies reveal a shift with greater awareness of the lay perspective, which typically favours a social model of adult mental ill health,¹⁷ and a matched response by GPs mirroring popular social constructions of distress.

Despite the challenge of responding to emotional distress in adolescence and the patchy, often inadequate provision of secondary care services,^{18 19} a series of policy directives have emphasised the role of GPs and other front-line services in the promotion of psychological well-being and the early indication of difficulties.^{20–22} Practitioners are expected to have 'sufficient knowledge, training and support in this area including competence in 'active listening' and conversational technique'.²³

There is a growing body of evidence examining young people's experiences of talking to GPs about emotional problems. Studies reveal a largely negative picture including young people being reluctant to disclose,²⁴ as well as a fear of being judged or being offered medication.²⁵ Much less is known about GP perspectives. This paper presents a qualitative, exploratory study which examines GPs' views and experiences of consulting with young people presenting with emotional distress.

METHOD

Study design

The study took place in the north east of England in 18 general practices based in urban, rural and semirural

communities serving predominantly socioeconomically disadvantaged patients. The qualitative study comprised in-depth individual interviews with GPs recruited using theoretical sampling. As early theoretical ideas emerged, successive GPs were recruited on the basis of their capacity to contribute to the development or abandonment of initial theoretical constructs.

Data were collected between January 2010 and May 2011.

Participants

GPs with less than 4 years of clinical experience were excluded. The initial recruits were selected on the basis of their relevant experience and their ability to generate early data, which would scope the terrain of the area under enquiry; for example, having a role as mental health lead or previous experience of working in Child & Adolescent Mental Health Services (CAMHS).

GPs were approached by telephone and email contact and sent information sheets. A follow-up contact established their verbal consent to meet at a location of their choice. Two GPs approached declined to participate. One cited forthcoming extended annual leave as a reason why he could not participate and the second GP held a view that as the senior partner he saw relatively few younger aged patients and suggested recruitment of a younger GP in the same practice.

Data collection and analysis

The audio-taped semistructured interviews were transcribed verbatim with consent. An initial topic guide was used with the first tranche of participants based on the extant literature and developed through discussion. The topic guide was then revised on the basis of ideas arising from the early interviews and the iterative analysis which began as soon as the first interview was undertaken. The interview guides explored doctors' experiences of consulting with young people in general and those presenting with psychological or mental health problems, GPs' understanding of depression and anxiety in adolescence, how emotional distress presents in the surgery and the role of the GP in promoting emotional well-being in young people (see online supplementary appendix 1). The guide was refined to include questions about how structural changes impacted on, and consultation style shaped, practice.

The interviews lasted between 50 and 75 min. Field notes and theoretical memos were kept throughout the period of data collection and analysis.

The transcripts were coded and analysed using the grounded theory method described by Glaser and Strauss²⁶ and revised by Charmaz.²⁷ The constant comparative method of analysis is core to the process and informs the theoretical sampling of recruits. Early ideas were tested with subsequent participants and found to be either substantiated or rejected through the iterative process of constant comparison supported by theoretical

sampling. Situational maps, 'messy' as well as 'ordered', were constructed during this phase of the analysis.²⁸

The data presented here were generated after the first level of analysis was completed, during which only the open codes were iteratively developed by JHR and subjected to further examination by AC (primary care academic) and JF (sociologist). Further analysis of the axial and selective codes will be presented in two subsequent companion papers.

RESULTS

Nineteen GPs participated, of which 10 were women (table 1). The early iterative analysis of the data found the open codes to support a dominant narrative of anxiety underpinning the majority of the research interviews. This pervasive and disabling emotional response to encounters with emotionally distressed young people appeared to coalesce around three domains.

These can be viewed as anxiety experienced by GPs in response to

1. Professional performance; in the consultation, at an external level, across disciplinary boundaries;
2. Interacting with young people;
3. The complexity of presentations of adolescent emotional distress.

Each of the three themes will be presented in turn and supported by illustrative quotations taken from the transcripts (see boxes 1–5). GP participants are identified by identifier number, gender, age range and whether salaried or a partner (as presented in table 1).

Anxiety related to professional performance

- i. Operating in the consultation: a coherent narrative emerged, gathered from almost all of the participants, of practitioners being anxious in the consultation because of an uncertainty about what to do and of what was expected of them as primary care clinicians.

This resulted in a sense of professional impotence. It was acknowledged that feeling uncertain about how best to proceed, and being unsure of practice, led to a sense of disempowerment through not knowing what to do. This was in contrast to accounts of working with older patients where the options for GPs appear to be more clearly defined. The data generated by the open code analysis suggested that not being able to formulate the initial presentation by a young person into a definable 'disorder' created a sense of operating in uncharted territory.

Anxiety was amplified by the lack of exposure to adolescent mental health in undergraduate medical education, which was the unanimous experience of all participants. Where the topic had been included in the curriculum, it was often restricted to severe mental disorder, for example, being assigned to medical teams looking after adolescents hospitalised with anorexia nervosa (see box 1).

- ii. Operating at an external level: a lack of benchmarks in practice meant that assessing one's performance in relation to peers was problematic since no 'gold standard' existed. The only NICE guideline which was referenced (concerning the management of depression in under 18-year-olds) was regarded as

Table 1 Study participants

Participant number	Gender	Age	S or P	Practice descriptor	Additional professional experience
01	Female	50–59	S	Semirural deprived	GP postgraduate education
02	Male	50–59	S	Urban deprived	Addiction medicine in primary care
03	Female	50–59	P	Urban deprived; wealthy student population	Former associate specialist in CAMHS
04	Female	40–49	S	Semirural deprived	Mental health lead for a PCT
05	Female	20–29	S	Urban deprived	
06	Male	40–49	P	Semirural largely affluent	
07	Male	40–49	P	Semirural mixed	Child protection lead for a PCT
08	Female	30–39	S	Semirural mixed	
09	Male	50–59	P	Semirural mixed	GP lead for 'teen drop-in' clinic
10	Male	40–49	P	Urban deprived	Mental health and child protection lead for a PCT; substance misuse
11	Female	20–29	S	Urban deprived	
12	Male	30–39	S	Semirural mixed largely affluent	
13	Female	30–39	S	Urban deprived	
14	Male	40–49	P	Urban deprived	
15	Male	40–49	P	Semirural mixed	
16	Female	20–29	S	Urban deprived	
17	Male	30–39	S	Urban deprived	
18	Female	40–49	P	Semirural affluent	
19	Female	50–59	P	Semirural mixed	Child health lead

CAMHS, Child & Adolescent Mental Health Services; GP, general practitioner; P, partner; PCT, primary care trust; S, salaried.

Box 1 Anxiety related to professional performance: in the consultation

- ▶ I'm quite anxious about mental health problems in young people cos I don't have a huge experience...and I don't want to waste their (CAMHS practitioners') time (09;M;50–59;P).
- ▶ I've always thought young people are challenging and still do and I have more questions than answers (06;M;40–49;P).
- ▶ I think they are a difficult group...partly because of the way they present...and there should be lots of resources for them and there aren't so not knowing what to do is a bit of a theme really...the main anxiety is what to do...(07;M;40–49;P).
- ▶ I find the adults will accept me at face value, generally. And they come with something usually fairly clear and they want that sorting out, it might not be straight forward, it might not even be simple they might have even brought things off the internet but it is a fairly clear baggage package...what I find with younger people with psychological or emotional disorders is it's not a clearly packed problem, it's in the extreme realms of the undefined (06;M;40–49;P).

having 'hampered GPs' from becoming involved in the management of adolescent depression since the guideline did not advocate the use of antidepressants, and with access to psychological therapies piecemeal, it appeared to support a position that there was little to be offered in primary care.

Constraints in practice led to frustration and an anxiety about management. For example, varying arrangements within practices governing access to appointments and the ease, or not, of maintaining continuity of care were seen to contribute to professional anxiety by impeding attentive 'watchful waiting', and some GPs described attempts to circumvent inflexible appointment systems in order to be more available to patients.

A lack of professional supervision was identified by a small number of more experienced GPs involved with postgraduate training and provision of mental health services at a regional level, which was in contrast to systems for other professionals working with emotionally distressed patients. Leaving GPs to rely on their own personal resources, on informal collegiate support or ad hoc relationships with colleagues in secondary care resulted in a fragile structure which could amplify rather than ameliorate anxiety (see box 2).

iii. Across disciplinary boundaries: GPs across the board expressed frustration with access to secondary care services, reporting long delays and frequent rejection of referrals and a lack of clarity about how the services were structured and governed. GP experiences and degrees of frustration varied with an emerging picture of problematic access to services being associated with higher levels of professional anxiety. Where GPs described more constructive cross-disciplinary relationships, with CAMHS practitioners offering clinical updates of meetings, and

Box 2 Anxiety related to professional performance: at an external level

- ▶ ...because it doesn't fit within any ticky box guidelines until time has passed I rarely know whether I've done the right thing, it's all in retrospect (06;M;40–49;P).
- ▶ I'll bring people back in 1 week, I don't think this annoys my partners but it can become a bugbear...I'll squeeze them in when there are no appointments, which is probably making a rod for my own back and I wouldn't encourage trainees to do it, but I like the idea of seeing something through to its natural conclusion...its perhaps my own insecurity (14;M;40–49;P).
- ▶ What we don't have, in general practice is supervision...no counsellors are allowed to work without it but GPs are just sent out there, and I really do feel there is a huge need for it even if it is just one phone call—it's that ability to share the responsibility, not to dump it, but to genuinely share it (04;F;40–49;S).

where consultants were accessible by telephone, less anxiety was voiced.

Unfamiliarity with the roles and responsibilities of CAMHS practitioners, coupled with an obligation to refer in the absence of other options, left some GPs feeling uncertain about the clinical care pathway and unsure about practice (see box 3).

Anxiety related to interacting with young people

The open codes showed a dominant finding of GPs expressing anxiety associated with difficulties experienced when communicating with young people in general. Neither the age nor the gender of the GP appeared to facilitate communication, with younger male and female GPs showing a similar level of uneasiness as older male and female GPs. Female patients were generally considered to be easier to talk with while young men were seen to be more challenging because of their perceived reluctance to seek help and their tendency to present late.

Box 3 Anxiety related to professional performance: across disciplinary boundaries

- ▶ I know we don't meet all the people we refer to but we usually have something to hang it on because of our experience as junior doctors working in hospital but with CAMHS there is nothing (08;F;30–39;S).
- ▶ Some (mental health) creatures are on the verge of being mythical beasts,...like psychotherapists,...educational psychologists (09;M;50–59;P).
- ▶ CAMHS...it feels like it's a bit of a hotchpotch really, a patched together sort of service and I'm not sure who is control...people who counsel children—I don't know much about them, how much responsibility they take...(07;M;40–49;M).

Communication difficulties included establishing a rapport, finding the right words and tone to use and dealing with silence. An inability to read the non-verbal signs, and to translate an often terse description from the young person into a coherent picture of their internal emotional state, left many GPs either relying on the accompanying parent or closing down the consultation. Being able to find common ground was identified as being key to beginning the process of establishing rapport.

Young people were seen as a highly heterogeneous group who showed variability from one presentation to the next (intravariability), and also across lines of age and gender (intervariability). Knowing what was 'normal' for an individual, particularly if it was presented as the principal reason for consulting with the GP, was perceived as problematic and anxiety provoking for the young person as well as for the GP (see box 4).

Anxiety associated with the complexity of presentations of adolescent emotional distress

GPs' accounts of their experiences in consulting with young people experiencing distress described a terrain beset with pitfalls, associated with the unspoken or with complex narratives embedded in social contexts, and presented in an undifferentiated form. GPs spoke of a sense of unpredictability and volatility to presentations which left them uncertain about how the patient narrative might unfold and how much input to offer at the initial consultation. In particular, this generated anxiety associated with the rare but grave consequences which might arise when a young person seriously attempted or completed suicide, a clinical experience to which many

Box 4 Anxiety related to interacting with young people

- ▶ Males with mental health issues worry me intensely, it really does seem that there is not an awful lot of trivia goes on there. By the time a male is presenting, because they don't have the tools to come to the GP very often, they don't understand that you can just come along when things are in their development, they usually come when something is really big, black and bleak (14;M;40–49;P).
- ▶ I struggle a bit to work out how to word sort of mental health questions with to the sort of under 16 year olds particularly... I suppose with adults I have my kind of, standard questions... but using those sort of questions with young people often draws a blank face, and, so it's something I have to rephrase; I feel that I don't necessarily know their kind of lingo if you like...(17;M;30–39;S).
- ▶ Generally consulting with young people, I often find, if I'm being honest, probably more difficult than I would expect to find it. I think I probably have this unrealistic view of myself as really sort of approachable and you know still being quite young myself compared to other GPs, being able to communicate fairly easily and fairly well with young people, then always very quickly, it becomes apparent that actually no, you are a million miles away from where they are, and they don't really relate to you very well at all...(08;F;30–39;S).

Box 5 Anxiety associated with the complexity of presentations of adolescent emotional distress

- ▶ ...you feel that there are these big 'no go areas' in teenage consultations, around sex, drugs, alcohol...which loom over you like a black cloud and I'm thinking that they want to talk about it and I'm thinking that I want to talk about it but we can't talk about it...(11;F;20–29;S).
- ▶ They are missing school, in trouble with the police, youth offending team or not uncommonly the parent just comes by themselves...I never get a 14 year old acting out saying 'you know, I'm in trouble with my mam and dad' (10;M;40–49;P).
- ▶ They are in absolute crisis one minute and then you see them a week later and they can hardly remember what it was all about (07;M;40–49;P).
- ▶ Its always a worry isn't it that you just completely get it wrong...I mean I'm conscious of this. I had someone in on Monday, parents, whose son had just hung himself at 21. I'd never seen him, he was a patient here. They had no idea anything was wrong. Nobody did...there is always that underlying things isn't there, that you might miss something catastrophic...(01;F;50–59;S).

GPs referred and which could lead to enduring professional anxiety (see box 5).

Although it was accepted that uncertainty as a feature of general practice was not restricted to the clinical area of youth mental health, the first-stage analysis showed a distinct narrative emerging in which adolescent mental health was seen as more notably anxiety provoking because of its more nebulous presentation and multiple confounding factors, which largely pertained to the social environment. The account given in the consulting room was described as the 'iceberg', indicating that often much is left hidden, or unsaid, but which nevertheless has to be raised at some point if the young person's distress is to be addressed.

Not only is there a dominant narrative of anxiety surrounding how GPs make sense of adolescent emotional distress, but also similar responses are associated with management options. Few GPs expressed any degree of confidence about how they would tackle individual presentations. A small number of those with additional roles in mental health or working with patients with substance abuse problems spoke of a more systematic approach in organising and offering care. However, even established GPs with personal experience of working in 'a teen drop-in clinic' or with drug-dependent patients described uncertainty about their practice. A paucity of treatment options was a consistent finding along with a lack of clarity about what GPs might reasonably be expected to do, if supported by adequate professional development.

DISCUSSION Summary

Anxiety about practice, coupled with a perceived reduced range of options and lack of clarity of

expectations, associated with diverse presentations of adolescent emotional distress in primary care, emerged from all GP participant accounts in the first-stage analysis. Unease when communicating with young people and difficulties in interpreting their accounts of distress inhibited the GPs. This was compounded by the complexity of presentations which ranged from familial discord school refusal to offending behaviour, usually in the absence of any clear diagnosis. The heterogeneity of adolescent behaviour taxed GPs, as did the unpredictability of the unfolding clinical presentation, which might settle spontaneously or might develop into a serious mental health disorder.

While there was a spectrum of levels of anxiety experienced by GPs, there was a prevailing universality about the experience. How GPs responded to and managed the perceived threat to professional competence and confidence was interrogated in the next stage of the analysis, which would lead to the development of the axial codes, or pillars, of the emerging conceptual model (presented elsewhere).

Strengths and limitations

The management of adolescent mental health problems remains an underinvestigated area of clinical practice. Previous research has largely been conducted by psychiatrists whose perspective is different from that of GPs responding to undifferentiated distress in the consulting room. Using grounded theory, augmented by situational analysis, permits a rich exploration of the territory and facilitates theory building.

Theoretical sampling supports theory development while not purporting to provide universal generalisability. After 19 in-depth interviews, buttressed by situational analysis, no new themes emerged and theoretical saturation was reached. All the respondents were white British and while they were recruited on the basis of their contribution to the study, it must be acknowledged that the absence of including the experiences of GPs raised and educated in different cultural contexts will lead to the silencing of other cultural perspectives.

The lead researcher and interviewer is a GP (JHR). Interviewing peers has been described²⁹ as enriching the data collection because of the shared knowledge and familiarity with the clinical territory, but it can lead to collusion between the interviewer and the respondent, which needs attention and reflexivity. Cocontributors AC and JF have academic expertise in social policy and sociology, which strengthened the analysis.

Comparison with existing literature

Heath³⁰ asserts that *a commitment to uncertainty is fundamental to general practice...* and Schon³¹ has described this operative landscape as a 'swampy lowland' proposing a model which advocates reflective practice as the key to dealing with uncertainty. A quest for certainty in areas of complex practice, especially when it concerns individual

experiences, can be counterproductive and scholars have cautioned against clinging to the 'shelter of diagnosis'¹⁵ when what is required involves attention to alleviating suffering and working purposefully with patients to catalyse their own creative capacity.¹⁴ Iliffe *et al*'s³²⁻³³ earlier cited work demonstrated that when GPs were fixed on the concept of depression as disease, they were uncomfortable talking to young people.

This study, which contributes to building a theoretical model, suggests that anxiety and perceived threats to professional competence can be experienced at multiple levels, and are amplified with regard to the complexity of adolescent presentations. This can compromise the GPs' professional engagement with young people. Understanding more about why some GPs can respond creatively to the anxiety and lack of certainty about expectations defines the next stage of the analysis.

Implications for practice and research

Inadequate educational preparation, both at the undergraduate and postgraduate level, is pivotal in failing to address the anxiety around clinical practice. Doctors need to be introduced to the developmental trajectory of adolescence and the conceptual framework which locates adolescence as the foundation of future health³⁴ in undergraduate education as well as revisited in continuing professional development. This approach will help GPs to understand more about why addressing emotional distress in the second decade of life is important.

GPs need good quality educational exposure and preparation to deal with the multiaxial development of adolescence and the emergence of mental health disorders in 10-year-olds to 20-year-olds. The current psychiatric classification systems do not facilitate clinical practice in this domain at the primary care level. In addition, the links between general practice and CAMHS need to be strengthened not only in terms of education and understanding more of how each discipline operates, but also at a pragmatic operational level. If cross-disciplinary practice was facilitated, more treatment options would be presented at a primary care or early intervention levels.

More research is needed to demonstrate evidence of effective, feasible, primary care-based brief behavioural interventions which would equip GPs to engage with young people with greater confidence and support the development of evidence-based policy.

At a systemic level, this study shows that external factors are important in influencing practice and can moderate or exacerbate levels of anxiety. Systems which improve access to care for young people need to be introduced at the practice level and be supported by policy.

Contributors JHR was the Lead researcher and had conducted all the interviews. She had performed the primary analyses and was the first author. AC and JF were involved with the study design from conception, met regularly throughout the analytical phase and commented on each draft of the manuscript.

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Competing interests None.

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Data sharing statement Extra data were available by emailing JHR on jane.roberts@sunderland.ac.uk, which includes theoretical memos, field notes, anonymised transcripts and situational analysis diagrams.

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