University of Sunderland

Roberts, Jane H. (2012) Challenging clinical encounters: an investigation into the experiences of GPs consulting with young people experiencing emotional distress and an exploration of the GP's role. Doctoral thesis, University of Sunderland.

Usage guidelines

Challenging clinical encounters: an investigation into the experiences of GPs consulting with young people experiencing emotional distress and an exploration of the GP's role

Jane H. Roberts

A thesis submitted in partial fulfilment of the requirements of the University of Sunderland for the degree of Doctor of Philosophy

July 2012

Acknowledgements

Abstract

Background

Young people who consult with their GP are known to have a higher psychological morbidity and accompanying emotional distress, than those who do not seek help. A small body of research has identified that GPs have difficulty in identifying emotional distress in this patient population unless it is severe. The implications of a low detention rate of distress by GPs include recurrent and enduring distress which continues into adult life and impacts negatively on social, educational, psychological and emotional development. Consultations with young people in this clinical arena can be problematic yet little is known about how the situation is perceived by GPs. In contrast, GPs are increasingly involved in responding to adults with emotional distress and psychological difficulties and their involvement has been well researched.

The research presented here explores GPs' views and experiences of managing emotional distress in young people who present in general practice.

Methodology

Grounded theory methodology was used, augmented by the application of situational analysis. Nineteen semi-structured interviews were conducted with practising GPs in the North East of England between January 2009 and July 2010.

Findings and conceptual theory

GPs vary in their degree of engagement with young people who present with emotional distress. This clinical terrain is perceived by the majority as being unfamiliar territory and creates professional anxiety and uncertainty. Three domains emerged as being pivotal in shaping a GP's response to this problematic situation. They are defined as a GP's performance in the clinical encounter; a GP's perspective of young people and their health needs and a GP's epistemological frame of reference. These domains form the pillars of the conceptual theory. The three areas intersect with each other to shape a

GP's engagement with emotionally distressed young people; which is translated in the clinical encounter as 'the enactment of role'.

Conclusion

A GP's role in responding to emotional distress in young people is ill-defined and unsupported. This results in anxiety and uncertainty about how to proceed. By developing a conceptual theory to explain what influences GPs' responses in this challenging clinical encounter it is possible to support greater involvement of GPs with young people who present with emotional distress. This has implications for education, practice, research and policy.

Table of Contents   Page Number

Acronyms

AYPH	Association of Young People's Health
BMJ	British Medical Journal
BMedSci	Bachelor Medical Sciences
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CPD	Continuing Professional Development
DSH	Deliberate Self-Harm
EBM	Evidence Based Medicine
GP	General Practitioner
NICE	National Institute of Clinical Excellence
NHS	National Health Service
PCT	Primary Care Trust
QOF	Quality Outcome Framework
RCGP	Royal College of General Practitioners
SFT	Solution Focused Therapy
UME	Undergraduate Medical Education

Chapter One: Introduction

This thesis presents an exploratory study of how General Practitioners (GPs) operating in the particular context of general practice, in the North East of England, understand, make sense of and respond to young people who present with symptoms of emotional distress, associated with psychological problems .

This is a relatively unexplored area in the literature yet concerns a significant problem of psychological morbidity in young people. It is reported that 10-20% of young people experience mental health problems which interfere with normal life (Singleton et al., 2001) (Office for National Statistics, 2008). Few services exist at a community level although a new and important exception to this is the initiative of increasing access to psychological therapies (IAPT) for children and young people. This project aims to extend training to CAMHS teams and embed evidence based practice across services. Unfortunately the funding model has not led to the creation of new posts in community based services so will not increase access to psychological therapies for GPs referring patients under 18 years of age (The Children and Young People's IAPT project, 2012).

Although a role for greater GP involvement has been raised at a policy level (Department of Health, 2004a), and advocated in one of the few NICE guidelines which concerns the emotional health of (children) and young people (National Institute for Health & Clinical Excellence, 2005), little is known and understood about what happens in routine clinical practice. A detailed review of the current picture will be presented in Chapter Two.

Even less is known about GPs' own views and experiences. Given the paucity of data and in-depth analysis conducted within this complex area of clinical practice, the study to be presented here is a qualitative study which focuses on the perspectives of GPs.

This introductory chapter to the thesis will set the scene by describing the research aims; provide a series of definitions of a number of the key terms;

present a summary of the researcher's multiple influences and outline the body of the thesis.

The research aim

This research aims to explore GPs' views and experiences of managing emotional distress in young people who present in general practice, using a grounded theory approach.

Definitions and concepts

In introducing this study it is necessary to provide a number of definitions and clarification of concepts which underpin the study.

General practice

This study is located in the contemporary setting of general practice as delivered under the auspices of the National Health Service (NHS) in the 21st century. A more detailed and historically contextualized description of what that currently means is offered in Chapter Two.

For the purposes of this study and in order to deepen the analysis, it has been decided to focus specifically on GPs rather than to broaden the focus and include other Primary Health Care practitioners, such as practice nurses. This is not to ignore the role that many other practitioners play in addressing emotional distress in young people in primary health care settings but permit a more in-depth study of one perspective.

Young People

In the context of this study 'young people' is the collective term used to describe those aged between 12 and 19 years (approximately). This age group sits within the WHO definition of adolescence (historically defined as the period between 10 and 19 years (WHO., 2001) and maps to the common understanding of 'the teenage years' as discussed in the literature pertaining to general practice and adolescence (Jacobson et al., 2002). The UN defines 'youth' as aged between 15 and 24 years (cited in (Sawyer et al., 2012)) ; however in the context of the research setting, early interviews produced data which suggested a cut-off point of 19 years marking the end of adolescence, was more consistent with the local cultural context.

The term 'young people' emerges from the social sciences literature dating from the mid 1990s which began to critique traditional concepts of childhood and youth. Social theorists James and Prout began challenging the dominance of developmental psychological theories which present the passage of childhood into early adulthood as a pre-determined trajectory where

> *Children are marginalized beings awaiting temporal passage through the acquisition of cognitive skill, into the social world of adults.* (James and Prout, 1997: 11)

The view that progression towards adulthood follows a clear, 'logical' and linear development is inextricably linked to Piaget's staged model of child development and notions of childhood and adolescence as 'stages' to be passed through. The influence of this epistemological and ontological perspective is enduring and can be seen influencing the practice of medicine today. 'Adolescent Medicine' as a sub-speciality is an obvious example whilst 'adolescence', rather than 'young people', appears to be the preferred term in the medical literature.

> *Adolescence tends to be understood in terms of biological and cognitive development through concepts such as 'maturation ' which glosses over children and young people's perspectives of their experiences and its meanings.* (Cheetham, 2010: 31).

This epistemological perspective accords passivity to young people which concurs with the paradigm of biomedicine and sees patients as 'objects' to be studied. In contrast the term 'young people', presents a different perspective to the biologically pre-determined journey of developmental psychology and understands the passage from childhood into adulthood as a socially constructed process.

> *As such it provides an interpretive frame for contextualising the early years of human life. Childhood, as distinct from biological immaturity is neither a natural nor universal feature of human*

groups but appears as a specific and structural component of many societies. (James and Prout, 1997: 80)

Emotional distress

This descriptive term has been chosen to refer to the undifferentiated distress a person might feel in the presence of psychological and mental health difficulties but is not necessarily associated with a 'mental health diagnosis'. Clearly it can co-exist with recognized mental health problems, but in the context of this study it describes the distress a young person feels in association with psychological difficulties, often of an inchoate nature. These may involve a presentation in surgery around, for example, family conflict, poor school attendance, 'anger outbursts', as well as somatic symptoms such as headaches, recurrent sore throats or abdominal pain.

'Emotional distress' has a further value as a descriptive term in that it does not accentuate the dualistic split of biomedicine which sees the mind and body as separate entities. As a non-specific term it does not prioritize mental or physical distress but may be associated with both.

A situated inquiry: the multiple influences upon the researcher

In qualitative research, behind the

> *'theory, analysis, ontology, epistemology and methodology'*
> *...stands the personal biography of the researcher who speaks*
> *from a particular class, gender, racial, cultural and ethnic*
> *community perspective.'* (Denzin and Lincoln, 2008: 28)

Below I will present a summary of the multiple perspectives which have influenced and continue to inform my practice as a researcher. [The thesis is written in the third person apart from sections which directly describe my own position].

Experiential influences

General Practice

I have worked as a GP for 15 years based in a number of different practices including being a Principal in an inner-city partnership, working as a salaried doctor in a practice specializing in health care for people with substance misuse problems, as a sessional doctor in an affluent market town and currently as a salaried GP in a former mining colliery.

My early practice was strongly influenced by the dominant biomedical model which underpinned my undergraduate education; although an intercalated BMedSci in Psychological Medicine helped broaden my vision and exposure to other frames of reference. Increasingly the experiences of working in a number of different settings combined with postgraduate study have shaped my practice and extended the knowledge frameworks upon which I draw.

I have a longstanding interest in child and adolescent emotional well-being and in exploring the role of primary care in supporting children, young people and their families where there are emotional and behavioural difficulties. Since 2009 I have developed and deliver an 'in-house' service with clinical supervision from a Child and Adolescent Psychiatrist (Roberts and Barnard, 2012).

In 2011 I was elected Chair of the RCGP Adolescent Health Group. The group is comprised of GPs and representatives from other primary health care based disciplines whose function is to foster a more 'youth-friendly' general practice culture through three main areas: education; the informing of policy development and advocacy for young people's health and their needs.

A sabbatical to Australia

In 2010 I was awarded a Churchill Memorial Trust Fellowship to travel to southern Australia to look at the development of 'youth-friendly' community based services for mental health; and to examine the relationship of general practice to new models of care. Australia is offering a compelling example of specialist youth health care provision (McGorry, 2007, McGorry et al., 2007a), and primary care academics have been at the forefront of developing educational initiatives for GPs looking after young people presenting with emotional distress (Chown et al., 2008, Sanci et al., 2000).

5

The experience of reflecting upon different models and perspectives has been enlightening and has informed and enriched my theoretical understanding and clinical practice (Roberts, 2012).

Family

I have four children and attribute much of my longstanding interest in child and adolescent emotional well-being to my growing family. Learning from my children has been illuminating and has made visible some of the competing influences and conflicts in young peoples' lives. This experience has challenged me to question my own assumptions about how young people see the world and how they make sense of adult behaviour.

Theoretical influences

Studying medical anthropology was a critical journey in expanding my theoretical framework for understanding health and illness, suffering and distress. In 2008 I was awarded an MSc from Durham where medical anthropology prioritizes a socio-cultural perspective, in contrast to a biological or evolutionary perspective. The Masters programme introduced me to cultural interpretative theory and critical medical anthropology and I found the latter was transformative in expanding my understanding of the multiple influences operating in health care systems. For example, in exposing and critiquing the exchanges of power between patient and practitioner in ways which are ordinarily hidden by the hegemonic process of 'normalization' embedded in western biomedicine. Foucault's critique of the connection between power relations and the formation of scientific knowledge (Foucault, 1975b) was an important discovery and informs the methodology of this thesis.

In critical medical anthropology I was introduced to the concept of 'structural violence' and have found this theoretical lens very helpful in understanding the patterns of illness and disease I see in the socio-economically disadvantaged communities where I have largely worked for the last ten years (Roberts, 2009).

Other postgraduate study has included Narrative Based Medicine (Greenhalgh and Hurwitz, 1998) which arises from the same stable as Foucault and other post-structuralists and offers both a practical and theoretical application to general practice. During my sabbatical I was able to revisit contemporary interpretations of attachment theory and latterly, its relationship to the cognate area of psycho-neuro-endocrino-immunological research on the impact of trauma and violence in early childhood (Kirkengen, 2010, Van der Hart et al., 2006). All of these theoretical influences have further extended my own epistemological frames of reference.

The thesis outline

This opening chapter will be followed by a review of the supporting literature which provides a background to the situation of inquiry. As will be explained in Chapter Two, in accordance with the tenets of grounded theory, the researcher needs to be familiar with the cognate literature without having an exhaustive knowledge at the outset. This is in contrast to investigative, rather than exploratory research, which seeks to test a hypothesis. In-depth knowledge of the extant literature is likely to prohibit the grounded theorist from approaching the situation of inquiry with an open mind and hence inhibit the development of a new theory to be grounded in the data. The literature review was subsequently added to as new themes developed inductively out of the data analysis.

The preliminary literature review is followed by Chapter Three which discusses the Methodology underpinning the study and the methods used to gather the data. This is an exploratory study which uses qualitative research. Grounded theory was chosen as the most appropriate 'theory/methods' package with *situational analysis*, a form of grounded theory to be used as the analytical framework for the data analysis. The theoretical foundation of the methodology and the paradigm in which it is located is discussed and its fundamental difference to the positivist paradigm of western science is made apparent.

The second part of Chapter Three describes in detail how the data was collected and the early stages of the analysis. Developing a grounded theory

is an iterative process with analysis of the data occurring simultaneously alongside the data collection. Both of these processes inform the subsequent recruitment of participants using the technique known as *theoretical sampling.* Early findings from the study are discussed in Chapter Four and include an articulation of the five key areas which appeared as problematic for the GP participants. Presenting the early findings allows the reader to see how the theoretical framework, to be presented in the following chapter, has taken shape.

Chapters Four and Five present the complete findings of the study. The first of these two chapters builds on the five 'problem areas' described in Chapter Three and which, after further analysis, led to the development of the three pillars underpinning the theoretical framework. The framework itself is then presented as a conceptual explanatory model, to be described fully in Chapter Five.

Chapter Six offers the discussion of the thesis. This chapter looks at the findings with regard to their originality and compares them to the existing literature. It also includes an appraisal of the relative strengths and weaknesses of the study.

The thesis concludes with the final Chapter, Seven, which examines the implications of the study findings and suggests recommendations to improve the care of young people who present in primary care with emotional distress.

<u>Chapter Two: Literature Review: The theoretical background</u>

Introduction

This chapter will critically discuss some of the theoretical and empirical literature which relates to the topic under investigation. Exploratory research which uses a grounded theory approach as its methodology (to be fully discussed in the following chapter) has a particular relationship to the supporting literature. A purist stance on using grounded theory would suggest that the researcher approaches the terrain from a naive perspective and develops their substantive theory inductively, based on the data gathered. Nevertheless, operating in 'the real world' precludes a researcher from investigating without some working knowledge of the territory. At the very least this is needed to produce a defensible research proposal which can withstand the rigors of an ethics committee and be sufficiently robust to approach funding bodies for financial support. An investigator who operates in a theoretical and empirical vacuum is unlikely to convince any external body of the value of their research intentions.

However, at the same time, using grounded theory requires a researcher to be open to all possibilities as they explore their situation of inquiry, in contrast to a study which uses a deductive approach and aims to substantiate or refute hypotheses. Creating a balance between an open, yet informed, perspective when investigating a relatively unexplored area of inquiry, is best achieved by constructing a preliminary theoretical framework which encompasses the broad aspects of the area under investigation (see (Urquhart, 2001: 12-13) without narrowing the range of theoretical possibilities.

Such a framework requires the researcher to be aware of the dimensions of the situation of inquiry through a familiarity with the published literature pertinent to the subject area and as such offers *theoretical sensitivity* (Glaser, 1978) which Glaser asserts

> *...is increased by being steeped in the literature and associated general ideas.*

A familiarity with the relevant literature allows for a theoretical framework to be constructed which can be further strengthened as the analysis deepens and suggests further directions to explore.

A Theoretical Framework

The literature review will be presented below in order to best contextualize the themes of the data analysis and to set the scene for the later exposition of the data findings (in Chapters Four and Five).

Whilst the aim of this research project was to explore GPs' views and experiences of managing emotional distress in young people, the analytical process led to a conclusion that unless the historical and cultural context of the general practice consultation was interrogated, the data analysis would be de-contextualized and void.

Having traced out the topography of general practice the literature review, concurrent with the data analysis, led to an examination of the competing epistemological frameworks in general practice, as represented in the literature. This cognate area led to an exploration of the published work which addresses the inherent uncertainty associated with much of clinical practice for GPs. The dynamics of the clinical encounter, including patterns of communication, the 'triadic consultation' and the specific ways in which GPs have used themselves as a therapeutic tool, will be presented here.

Following on from this position, the literature review discusses how GPs have been reported to deal with emotional distress in adult patients. Armed with this knowledge, the interrogation of the literature moves into examining more closely what is known about the management of young peoples' emotional distress and mental health from a broad and global perspective. This chapter concludes with a review of the published work and the grey literature which focuses specifically on the practice of responding to young people's emotional distress in a UK general practice setting; thus leading into the research aim under question.

These six broad areas which form the scaffolding of the theoretical framework will each be discussed in turn and are summarized below.

1) The structural and policy context

2) Competing epistemological frameworks in general practice

3) Professional anxiety and uncertainty

4) 'The consultation'

5) The management of emotional distress in adults

6) Young people's mental health

The structural and policy context

Clinical care is not offered in a vacuum**.** Any examination of 'the doctor-patient' interaction is only meaningful if it is located in a socio-historic context which acknowledges the competing external influences.

Examined at a meta-level the human manifestations of illness are shaped by the culture in which they arise. Ivan Illich (1974), a polymath and critical theorist offered a critique of modernity which included a position that modern western culture

> *defines suffering as a technical problem...He (thus) argues that our expectations, shaped by our 'consumer demand for increased medical outputs', generate a new kind of suffering.* (Illich I, 1974) cited in (Reeve et al., 2011)

Anthropologists have added to our understanding at the meta-level by introducing illness representations as 'culturally constituted illness realities', referring to the 'meaning centred tradition' (Pool and Geissler, 2005: 35) which draws on the work of Kleinman (Kleinman et al., 1978). This use of this lens resulted in the 'so-called culture bound syndromes' (Pool and Geissler, 2005: 30) which were 'mainly mental disorders thought to exist only in specific cultures' (ibid). Historically the focus was on 'exotic cultures' but then moved to consider the contestability of 'universal' Western psychiatric categories, such as schizophrenia to question whether this too was a 'culture-bound syndrome' (ibid: 30).

Taken at a more proximate level, the influences of political ideology and decision making, translated into government policy, shape how doctors respond to patients' presentations of illness. An examination of the influence

of policy includes both direct edicts which guide clinical behaviour, such as the influences of nationally agreed GMS contracts, for example the 2004 contract which introduced a significant element of 'pay-for performance' (British Medical Association, 2003), and nationally approved guidelines from the National Institute of Clinical Excellence. It also includes an understanding of how general practice performance is judged which introduces the concept of 'clinical governance'.

A summarized selection of the literature critiquing these external influences upon clinical practice will be presented in this section, following a brief resume of the recent socio-historic context of the National Health Service (NHS) in the UK.

The NHS: An abridged historical context

Tudor Hart describes the 1970s as 'a golden era' for the NHS where patient care was 'more effective, more humane and less authoritarian' (Tudor Hart, 2006: 1)

By 1980 although the NHS was still considered to be operating as a 'gift economy', in accordance with its early post-war roots as a fundamental prerequisite to a healthy and just society, the economic framework was changing. Tudor Hart describes the shift of NHS care from being a public service to an industrial model as 'managed care' (ibid: 15) and he documents the progressive move from the 1980s onwards, to an increasing fragmentation of the NHS and a rise in bureaucracy. This model was further extended with the practice of 'Fund holding' in the 1990s which formalized and rewarded the concept of internal competition by allowing GPs to hold budgets with which to purchase services.

Once the NHS moved from a 'gift economy' to a capitalist model with its 'users' viewed as consumers, the provision of healthcare changed both covertly and overtly. Payment for services would lead to a prioritizing of certain clinical activities which offered financial reward given that general practices remained as independent small businesses and sought to run at a profit. This shift of clinical activity in response to financial rewards was cemented with the introduction of the 2004 'new' GP contract (Department of

Health, 2004b).This contract offered the option of locally agreed Personal Medical Services contracts rather than a nationally negotiated contract.

Moreover it introduced performance related remuneration through the Quality and Outcomes Framework (QOF). The 2004 contract extended the role of primary care to undertake enhanced services, introduced diversified professional roles with a blurring of traditional boundaries, introduced Practice Based Commissioning and introduced alternative points of access to primary medical care such as NHS Direct.

The Quality Outcome Framework: Living in a 'QOFable' world (Campbell and Lester, 2010)

In 2004 the QOF was a new and previously untried system of linking performance to payment. At the time it consisted of a collection of 146 'evidence-based' indicators of quality for which practices had to demonstrate proof of collection in order to receive a financial reward.

Although linking performance to payment is not in itself a new phenomenon the format of the QOF was unprecedented in the proportion of income it could generate for a practice. There is also controversy about 'the validity of the indicators' developed by an 'independent expert group' (Kramer, 2012). It is an initiative which has captured the attention of academic clinicians globally, is viewed as a radical policy that 'vaults over anything being attempted in the US' (Shekelle, 2003) and is regarded as a watershed in the delivery of primary healthcare with its arrival invoking the potential to be called 'a requiem or renaissance in general practice' (Marshall, 2002). The UK is the only western country to run such a programme and its outcomes are being observed and analysed in New Zealand and Australia (Mangin and Toop, 2007,Toop, 2011) before being replicated.

The extant literature discussing the QOF has a dichotomous split. Those in favour credit the QOF for supporting an improvement in diabetic and asthma care at rates which exceed pre QOF comparisons, with coronary heart disease (CHD) maintaining improvement at the same rate (Campbell et al., 2007). Others report that the management of non-incentivized conditions has

not been compromised and remains constant, although this finding gives no substantive indication regarding future trends (Steel et al., 2007).

This position is challenged by those who contest the *a priori* assumption that collecting 'QOF points' equates to providing good clinical care and such critics pose a number of philosophical and epistemological questions (Heath, 2007,Heath et al., 2009) . These can be summarized in asking how appropriate and useful is it to focus on the value of offering 'silo organized' care where 'most patients presenting in primary care have multiple, interacting, and compounding problems-physical, psychological and social?' (2009: 911). In asking what is the role of context in illness and disease?

Who or what now defines the agenda of the consultation? Are numbers all that matter? Which knowledge is the more legitimate? Where is the new focus in the consultation? Heath and colleagues are unequivocal in asserting that the QOF

> *diminishes the responsibility of doctors to think, to the potential*
> *detriment of patients, and encourages a focus on points scored,*
> *thresholds met, and income generated.* (Heath, 2007: 1075)

 The latter point is supported by Mangin & Toop (2007) who suggest that the UK's adoption of the QOF has put into question core values at the heart of general practice relating to professional values, the nature of professionalism and the concept of good care. They argue that the framework accords greater status to 'what is written or coded than what is said between doctor and patient' and its uncritical acceptance of 'central authority' jeopardizes a profession which risks losing its 'knowledge base and priorities' for financial reward.

The impact of the Quality Outcome Framework on general practice culture
Toop (2011: 432) suggests 'themes are emerging of deleterious effects on the consultation and upon the work of both GPs and practice nurses, and he cites a number of references to support this assertion (Dowrick et al., 2009, Kendrick et al., 2009, Mitchell et al., 2011).

Two papers from different authors which interrogate the impact of the QOF on contemporary general practice were studied in detail for this literature review. The first was an ethnographic study by McDonald and colleagues which looked at the QOF's impact on individual and group attitudes, and patterns of behaviour in two general practices in England. The authors concluded that the arrival of QOF on to the general practice landscape did not appear to have 'damaged the internal motivation of the GPs studied, although more concern was expressed by nurses' (McDonald et al., 2007a: 1357). This study revealed the discursive work GPs performed to align financial incentives with professional values. They viewed the QOF as improving practice by streamlining, standardizing and rewarding 'good practice'. The advent of QOF has introduced new regimes of surveillance within practices which were readily discussed by participants and supported a construct of "the chasers" (those who pro-actively pursue data gathering to meet 'QOF targets') and "the chased" (those who are pursued by colleagues to be more pro-active in collecting QOF related data). However, even where GPs described draconian practices within their surgeries, those who felt 'chased' still supported the rhetoric of incentivized payments.

The nurses who participated in the study felt the least able to resist the increased scrutiny which has resulted from the increased surveillance supporting the Framework, with the clinician-patient interaction, once traditionally beyond observation, now open to external monitoring by peers and employers. The researchers found that "free-riders" (low 'QOF active' colleagues) were not popular but there was no organized or collective articulation of an opposition to this 'new form' of general practise.

The second paper examined was a related study by Checkland and colleagues (Checkland et al., 2008) which used two linked ethnographic studies to explore in greater depth the effect of the new pattern of incentivization on four practices in England and Scotland. They present the discursive work performed by GPs in accepting the QOF and its attendant epistemological underpinnings, and find three overlapping strategies which permit GPs to 'make discursive claims that they provided holistic care'. These strategies centred upon three areas: 1) the creation of a metaphorical

'protected space' within the consultation in which the GP could remain patient centred; 2) an ideal of complexity management for the GP in a 'quasi specialist' role with delegation of QOF tasks to nurses (with or without negotiation) and 3) GPs maintaining an overview of patient care which now equated with 'holism' and replaced former definitions more dependent on relationship based care.

Changing professional identities

As mentioned earlier the Quality Outcome Framework was associated with a diversification of professional roles. This has contributed to a changing landscape of contemporary general practice with a reconfiguration of roles and responsibilities in response to the wider externally imposed changes on the profession and its organization. How these roles have evolved and developed can be understood with reference to Giddens' Structuration Theory (1984), a theory of the relationship between agency and structure which focuses on social practices. New professional roles have emerged in response to the enactment of external agendas, to which many of the profession have contributed; such as participating on clinical commissioning groups or indirectly by accepting the directive of the 2004 contract and altering practice without critical debate. Structuration theory describes the iterative dynamic relationship which exists between social practice and the social structure which permits the practice:

> *...in expressing themselves as actors, people are engaging in practice and it is through that practice that both consciousness and structure are produced.* (Ritzer and Goodman 2003: 510)

Thus as general practice has been remoulded externally it has refashioned itself internally.

An ethnographic study by Charles-Jones and colleagues (Charles-Jones et al., 2003) presents a theoretically robust analysis of the data examining the transformation of general practice and the redistribution of work roles and responsibilities. [The fieldwork was conducted in 2000-2001 before the introduction of the 2004 contract.]

Using the theoretical concept of 'the constituting of classes' which seeks to produce 'hierarchies of appropriateness – of work, patients and personnel' (ibid: 72) the authors find a general practice which now organizes itself around a new distribution of work carried out by 'intense hierarchies of distinction - not just (of themselves) as professionals, but of patients and work'. The authors see general practice as having become the theatre for performing technically competent and externally accountable bio-medicine, and no longer the site for the practice of traditional, biographical medicine. They describe 'an effacement of the social' occurring in general practice (ibid: 72). In this transformed world patients

> *are reduced to the condition or tasks that are required in order to 'dispose of them' and patient-hood has been reconstructed now as an object of 'clinical-managerial surveillance.* (ibid: 79)

Of salient detail is their conclusion that

> *Those patients requiring the most technical expertise are the most valued.* (ibid: 75)

By implication, those whose problems are viewed as predominantly psychosocial will be amongst those least valued. In their study Charles-Jones et al identified two conditions where GPs continue to act as 'the family doctor' and the discourse of care is still one of 'personal relationships and continuity, not delegation'. These clinical scenarios concern adults with mental health problems which are seen as 'complex' and patients with terminal care needs. In these domains the GPs were seen to 'construct an identity that links them morally and ethically to their traditional identity as a 'family doctor' .They conclude that

> *ironically, the new active management of primary care is justified by drawing on the traditional moral discourse of "patient centredness".* (ibid: 72)

The Salaried Doctor

One of the demonstrable changes on the landscape of general practice has been the increase of salaried GPs whilst the number of principals has remained constant (The NHS Information Centre— Workforce and Facilities, 2009). A study which sought to interrogate the perspective of salaried doctors develops further the argument outlined by Charles-Jones et al that a 'new culture of general practice' has emerged (Jones and Green, 2006). Jones & Green argue that the new culture is said to

> *resonate with the social values of reflexive modernisation and has the potential to enable new, less paternalistic, forms of relationships with clients.* (2006: 927)

In a qualitative study which involved interviewing GPs early on in their careers, there was a dominant view that the salaried role offered a preferable work/life balance described as 'nice work'. The authors argued that 'the most significant change is the de-coupling of vocationalism from professionalism '. Proponents for 'the nice work' model of salaried practice see their stance as in the patients' best interests:

> *Resistance to a traditional vocational model was constructed as healthy and morally worthy, in that it was in the ultimate interest of clients and other colleagues as well as the GPs themselves.* (2006: 944)

Not only was bounded work, which drew upon externally agreed guidelines and promoted patient autonomy, seen as preferable to open ended relationships which risked inviting 'doctor dependency' but it was also represented as being the apotheosis of patient-centredness (Jones and Green, 2006). Other authors have contested this strongly affirmative view of the salaried status and found GPs to be describing a sense of inhabiting a 'second-class status' with the least attractive duties falling to the salaried doctor (Lester, 2009).

Consultation length

The literature suggests that collectively the 'ten minute' consultation is an obstacle to developing a trusting and potentially therapeutic relationship; both for GPs (Illiffe et al., 2012) but also for patients, and their families (Sayal et al., 2010) who have asserted that short consultation times are a barrier to opening up about sensitive issues.

There is a growing trend towards calling for longer consultations which has been borne out of research which demonstrates that longer consultations lead to greater enablement (Fitzpatrick et al., 2007) and patients with complex presentations, often involving co-morbidity (both characteristics would be represented by young people with emotional distress) need longer consultations (Lakhani et al., 2007). A recent editorial summarises the 'intense pressure on the 10-minute consultation' and suggests that the situation is untenable (Silverman and Kinnersley, 2012). The authors suggest that with longer consultations 'more psychosocial problems are recognized' and GP stress is diminished (Fitzpatrick et al., 2007).

Competing epistemological frameworks

Background

On the backdrop of this socio-political map of general practice a landscape of competing epistemological frameworks has evolved. Such frameworks are built around contrasting sources of knowledge which reflect differing ontological positions, ultimately referring to alternative perspectives on what is 'truth' and 'reality'.

One approach to begin to understand how GPs, initially as a collective body, have made sense of their practice might be through the medium of the Royal College of General Practitioners (RCGP). As a College it dates from 1952 with its royal charter issued in 1972. There are clearly other perspectives for critiquing a collective body but the RCGP has an established and visible presence and not least, houses a repository of literature which has contributed to defining 'what general practice is', largely through a series of 'occasional papers'.

From its early days literature exploring the identity of general practice has been concerned with both articulating its own position and distancing itself from models of practice which have evolved from a hospital context.

'Patient-centredness'

Once general practice began to be studied as a substantive entity the notion of caring for the patient rather than the practice of 'a science' emerged as a dominant narrative and although it is understood through a myriad of lenses the centrality of 'patient centredness' in the rhetoric of general practice continues to take centre stage.

The concept known as 'patient-centredness' first entered the lexicon in the late 1960s and early 1970s evolving from Michael Balint's earlier pioneering examination of 'the doctor-patient' relationship (Balint, 1957). In 1969 his wife Edith Balint, a psychoanalyst, described 'patient centred medicine' as '*understanding the patient as a unique human being*'. Such intellectual insights, coupled with a changing political landscape with regard to the enacted identity of general practice, informed a landmark document published by the RCGP entitled 'The Future General Practitioner' (Horder et al., 1972) which defined general practice as being concerned with 'the patient's total experience of health'. This seminal work is credited by Howie (2004) as coining the phrase 'patient-centred practice '.

At its heart, patient centredness developed out of a foregrounding of the doctor-patient relationship which placed the consultation as 'the corner-stone' and the patient to be considered as a 'unique human being' (Balint, ibid). This epistemological position placed it in contrast to the hospital model which prioritized a view of medicine as a science and the patient as a subject: the very enactment of biomedicine.

Biomedicine

Biomedicine, indeed western science, represents a particular ontological and epistemological perspective which sits in a positivist paradigm (to be discussed in more detail in the following chapter). Western science is materialist. It assumes that reality is material and that scientists can obtain

objective knowledge of it independently from the methods used (Pool and Geissler, 2005). As such it represents a (dominant) cultural system amongst other possible ways of understanding illness and suffering. Positivism is predicated on the idea of reductionism, a notion that considers complex phenomenon can be understood by reducing them to their most basic properties. As such biomedicine considers that human beings can be 'explained' by their molecular biology.

Biopsychosocial medicine

This view, uncontested, sat at the heart of hospital medicine and its practice but which offered an ill-match when transposed into the context of general practice.

The 'doctor-patient' relationship was accorded a higher priority in the 1970s during which time a view developed that the broader context of a patient's life also played a role in expressions of illness and needed to be taken in to account. These ideas led to the creation of the concept of *biopsychosocial medicine* as first described by Engel (1977). His view of 'general practice medicine' was that it required more than a focus on either the biological or the doctor-patient interaction but should include a wider view of cultural, social and psychological factors. Engel's legacy was to offer the profession 'the biopsychosocial model' which is considered 'both a philosophy of care and a practical clinical guide' (Borrell-Carrio et al., 2004).

Biographical medicine

Other theorists have disagreed with the claims of the proponents of *biopsychosocial medicine.* Armstrong, a Foucauldian scholar, has described it as 'the old [biomedical model] with gloss'(Armstrong, 1987).This is a position informed by the philosopher Michel Foucault who argued that the positivist notion of science taking us ever nearer to 'the truth' was fallacious and biomedicine is as much a cultural system as any other. Foucault explored the idea that cultural systems are not 'value- free' or neutral and are deeply situated in their history. Thus knowledge is not independent but historically embedded; a process Foucault called '*genealogy*' or the

historizing of knowledge which was previously assumed to be ahistorical; such as, for example a history of 'the body' (Foucault, 1961, Foucault, 1966).

Armstrong developed his ideas about general practice in a seminal paper *'The emancipation of biographical medicine'* (Armstrong, 1979) in which he traced an emphasis on the biographical elements of the patient's problem and postulated that a re-framing would allow for the definition of general practice's own identity to emerge, one separate from the tradition of 'old clinico-pathological hospital medicine'.

Others have suggested that general practice did not embrace *biopsychosocial medicine* beyond the rhetoric and have drawn upon empirical data to support their argument. Dowrick et al., (1996) conducted a questionnaire study to determine which topics GPs considered to be 'appropriate' or 'inappropriate' to 'a general practitioner's knowledge and skills' (ibid). The authors found that the reality of practice was a prioritizing of acute and chronic physical problems and psychological problems by GPs but little interest in social problems and thus concluded that the 'biopsychosocial' model was more 'rhetoric than reality'.

In seeking a comprehensive knowledge framework for general practice the 'vagueness' of patient-centredness has been deemed problematic (May, 1999) and other scholars have called for 'complexity' to be regarded as 'the essential defining feature of holistic general practice' (Checkland et al., 2008). This perspective has evolved from diverse and disparate epistemological schools including experimental mathematics, evolutionary biology and the social sciences (Griffiths and Byrne, 1998). The complexity theorists have described further frameworks which attempt to articulate how GPs deal with the uncertainty of much of clinical practice (Griffiths, ibid) by advancing

> *a dynamic model of practice which recognizes the changing nature of illness....and seeks to avoid contributing to a myth of medical certainty.* (Reeve, 2009: 23)

Evidence-based and interpretive medicine

A turn in the way in which knowledge is used in practice was heralded by the birth of *Evidence-Based Medicine* (EBM) (Sackett et al., 1996) which contested the ontological and epistemological paradigm of a biological – biographical lens and sought to buttress diagnosis and clinical decision making. EBM sees 'best' evidence as having

> *an epidemiological emphasis on statistical analysis of empirical observations of defined disease within populations, undertaken by scientific method rather than based on clinical experience and providing objective knowledge including quantative estimates of the 'certainty' of that knowledge.* (Reeve, 2009: 8)

Its proponents acknowledged its roots in the hospital medicine of 19th century Paris where data was derived from secondary care patients who represent a different group to those seen in primary care, where illness by definition is undifferentiated.

In her elegant critique of how current knowledge systems and their adoption can shape practice, Reeve develops her argument for an alternative epistemological framework which addresses the 'epistemological uncertainty' (Fox, 2002 cited in Reeve, 2009: 23) which characterizes general practice. Reeve terms this alternative frame of reference *Interpretative Medicine* and suggests it is 'a new model of knowledge and practice for patient centred general practice'; defined as

> *the critical, thoughtful, professional use of an appropriate range of knowledges in the dynamic, shared exploration and interpretation of individual illness experience, in order to support the creative capacity of individuals in maintaining their daily lives. (*2009: 62)

This definition encompasses *Narrative Based Medicine* which originates from a common ontology and has been proposed as a (practical) way to respond to the complex reality of patients' lives , informed by the insight gained from post-modernist ideas (Launer, 2002). Within *Narrative Based Medicine*

Launer offers a seven layer conceptual framework: described as addressing conversation, curiosity, contexts, circularity, co-construction, caution and care which can act as a pragmatic framework for the consultation (ibid).

Reeves' model of *Interpretative Medicine* pivots around the view of general practice as being 'about interpretation of illness, not identification of disease (2009: 21) and the author proposes

> *a framework by which we can evaluate the quality of knowledge generated within generalist interpretive clinical practice.* (2009: 3)

Interpretive Medicine offers a hopeful vision for general practice by suggesting, at an abstract level, that practical wisdom *(phroneis)* practised in routine general practice has survived the colonization of intellectual thought (S*ophia*) by EBM and continues to value the biographical accounts of human experience as valid and epistemologically central to its everyday practice.

In contrast the literature examining the impact of QOF has suggested that the current political landscape has had a deleterious impact on the praxis of general practice (Dowrick et al., 2009, Mitchell et al., 2011). It suggests that the centrality of the patient's narrative has been usurped by the doctors' agenda (Tonelli, 2007).

In seeking to legitimize this move away from prioritizing biographical accounts of illness the new narrative emerging in the literature seems to be concerned with a re-framing of a new way of working as 'more patient centred' (Jones and Green, 2006). At the same time discourses of holism and 'patient centredness' remain central to professional 'self-presentation' (Checkland, 2008: 792). 'Patient centredness' now appears to mean 'all things to all men' and its appropriation by contrasting epistemological frames of reference makes its usefulness problematic.

Dealing with uncertainty and anxiety in the consultation

Heath asserts that

> *a commitment to uncertainty is fundamental to general practice:*
> *the responsibility to know what we do not know, to be clear about*
> *our uncertainty.* (Heath, 1999: 651)

This assertion sees medicine as

> *unique in aspiring to be a science whose object is also a subject*
> *....The grounding reality of medicine is the patient's subjective*
> *story of their symptoms. Everything that comes after is an*
> *approximation of the reality.* (ibid: 653)

The tension which arises from these competing vantage points lies at the heart of clinical practice.

One theoretical approach to this prevailing uncertainty in professional practice has been developed in the work of Donald Schon with his work '*The reflective practitioner*' (Schon, 1983) now accepted as part of the cannon of general practice literature. Here, Schon articulates the relationship between knowledge and practice and the uncertain hinterlands which he describes evocatively as the 'swampy lowlands'. He suggests that experiential knowledge is developed though 'reflection-in-action' and 'reflection-on-action'. Schon describes two typologies of relationships between the professional and, in this context, the patient, in which he sees GPs as acting either as 'the traditional expert' or as one who invites the patient into a reflective dialogue (1983) cited in (Lykke et al., 2011). Thus he proposes an alternative model for consultations which evoke professional anxiety.

A search for further theoretical approaches to this core element of clinical practice in primary care is offered by Geneau and colleagues (Geneau et al., 2008) who introduce the concept of *ontological security*. This is a term taken from Giddens' structuration theory (Giddens, 1984) which the authors use as a theoretical lens to interpret the empirical data they generated, using a case study methodology. The authors' data revealed

that developing a sense of security is one of the predominant facts and preoccupations shaping GPs' professional experience and practice. (Geneau et al, 2008)

Creating predictable routines and working within a bounded territory reduces the level of uncertainty at the heart of general practice. The authors' identified four conditions of action which framed clinical behaviour and which could provoke or ameliorate professional anxiety. They suggest that mode of remuneration, peer-to-peer interactions, patient demands and the availability of other medical resources directly influenced the 'performance of medical acts and time management, as well as the degree of specialization of GPs'. Geneau et al suggest that

GPs are partly driven by the desire to reduce the level of uncertainty in their daily activities, and each individual has his or her own degree of risk awareness. (2008:20)

How a GP deals with uncertainty will be influenced by their preferred knowledge framework and by their behaviour in the consultation. The section below will look at the literature which pertains to 'the consultation' and to how GPs have been observed to operate, particularly when dealing with more ill-defined clinical presentations where the psychosocial elements of a patient's narrative are significant.

'The consultation'

The literature to be reviewed in this section examines aspects of the consultation from both a sociological and psychodynamic perspective. It will summarize the literature about the triadic consultation and look at studies of GP performance in the consultation. The section concludes with an interrogation of the literature which studies the potential of the clinical relationship to be used as 'a therapeutic tool'.

An initial scoping search of 'general practice and consulting style', from the data bases Science Direct and Web of Science generated 8,566 hits. This was narrowed down from 1,298 ('doctor-patient communication') to a list of

19 articles by using the search term 'General Practice and doctor-patient communication' and 'consultation style'. The list was appraised and abstracts related to the study were selected for further reading before deciding whether the article needed to be read in full.

A paper by Bower and colleagues (Bower et al., 2001) offers a coherent analysis of the multiple and varying ways in which 'the consultation', long viewed as the '*essential unit of medical practice*' has been examined; and as such offers a framework for looking at the aspects of the (vast) literature which are relevant to this study. The authors identify four domains of consultation research and locate their summary in a historical context. They suggest the consultation

> *has been shaped by political pressures - to differentiate itself from other kinds of medicine, and to accommodate the demands of patients - and by epidemiological factors impacting on workload, as well as by its own internal logic.* (2001: 5)

The four domains the authors propose are the psychodynamic; the sociological; the clinical-observational; and the social-psychological. The first two domains listed appear to have greatest relevance to the situation of inquiry and were examined for relevant studies.

The consultation as a sociological domain

With respect to the research topic and the chosen methodology it seemed appropriate to consider studies exploring aspects of doctor-patient communication which might help or hinder open discussion in a consultation which addressed 'difficult' and/or 'sensitive' topics. A number of such studies collectively spoke of a doctor's degree of *situational awareness* and sat within the sociological domain of research on 'the consultation'.

Situational awareness

One such study found that the manner by which a patient expressed their distress was more important in influencing a GP's 'communication style' coupled with their awareness of patients' psychological problems, than was being under pressure from *a long patient list or busy moment of the day*

(Zantinge et al., 2007). This finding challenges the anecdotal assumption that it is pressure on time which largely influences the content of the consultation and considers that a doctor's degree of *situational awareness* is also important.

Doctors' varying degrees of responsiveness within a clinical encounter was explored in great depth in a large scale, Department of Health funded, qualitative study exploring how GPs and patients communicated about medication (Barry et al., 2001). Multiple analyses were performed on the linked data sets including a critical discourse analysis on 35 transcripts. The analysis reported in the paper cited (ibid) referred to Habermas' Theory of Communicative Action as an underpinning theoretical structure and called upon Habermas' idea of 'a lifeworld voice' and a 'medical voice'. The authors identified

> *four broadly different patterns of communication according to whether the voice of medicine or the voice of the lifeworld was used and by whom, doctor or patient.* (2001: 493)

 They found that communication strategies moved dialectically between the 'lifeworld' and a 'strictly Medicine' world with movement being 'situation specific' rather than due to the fixed dispositions of individual doctors. The study data demonstrated that all the GPs shown to be working to a 'mutual lifeworld' model in the study also had the capacity to operate in the voice of 'strictly medicine' on other occasions, thus showing flexibility of approach rather than fixed personality traits. They concluded that the 'increased use of the lifeworld makes for better outcomes and more humane treatment of patients as unique human beings'. The data also suggested that the positions GPs adopt are not immutable or secondary to personality, but are in response to the dialectical relationship between consultation content and style and the dynamic, inter-relational behaviour between doctor and patient.

Habermas, a Marxist social theorist, has made a major contribution to social theory on communicative action (Ritzer and Goodman 2003: 529) with his conceptualization of society as *a life world* offering another lens on understanding human behaviour. He postulated that there were three forms

which the human and social sciences could take: 'the empirical, the interpretive and the critical' and these distinctions could translate into different ways of understanding human behaviour: from an instrumental, communicative or reflective position (Carr, 1986).

In another study of the consultation, conducted in the US, the themes of *situational awareness* and moving between worlds is examined by an exploration of the processes in the clinical encounter (Katz and Alegría, 2009). The authors present 'exemplars of how assumptions of both clinicians and their patients can shift or transform in the course of a diagnostic interview' (2009: 1238). They propose that being aware of and

> *shifting away from assumptions can promote engagement: it is a moral act. (*2009: 1245)

The paper speaks to the social distance which can arise in consultations between doctor and patient and of the role of reflection to determine what is important for both parties, in order to change the focus from individuals to the interpersonal relationship. They suggest

> *a language of relationships, not attributes is really needed.*
> (Goffman, 1963)

and consider the clinician as 'an anthropologist' who moves between the *lived world* , that is to say 'the local, moral world' (Kleinman, 1999) and *the medical world.*

The consultation as a psychodynamic domain

Following the grid described by Bower and colleagues and referred to earlier (ibid; 2001), the second of the four domains of the consultation which is relevant to the study in hand looks at the *psychodynamic processes* which can occur during a consultation. Early interviews introduced the idea of young people as a 'difficult group' in general practice so literature exploring how GPs dealt with 'difficult patients' was examined for relevance to the study in question.

The tone of many of the interviews, supported by a selection of case vignettes, seemed to evoke the connotations of the adult 'heartsink' patient hence a search for this literature was undertaken. The emotive descriptor 'heartsink' is said to have been coined by O'Dowd (1988) in an original research paper which described a study of 28 (adult) patients who were considered to trigger a negative affective response on the part of the doctor.

Despite the inherent ambiguity of the term for 'it is the doctor's heart who sinks but the patient who receives the label' (Moscrop, 2011) the term was adopted with enthusiasm and a recent paper both measures the popularity of the term and offers a reflective critique of its role in understanding 'difficult consultations'. In his paper Moscrop explores the influence of 'heartsink' as a concept in general practice and considers the psychodynamic potential this lens offers. He suggests that 'heartsink' has a clear relationship to established psychodynamic concepts of transference and counter transference and may illuminate why certain consultations are experienced as being more difficult than others.

To this end he considers the implications of 'heartsink' as a phenomenon invoking 'an appeal for more reflective practice'. He advocates maintaining the focus on 'heartsink *relationships*' to avoid the 'concrete externalization' of the problem with a patient being viewed as inherently 'difficult'. By switching the focus to the dyad it removes apportioning blame for a 'difficult consultation' from the patient. There is clearly direct relevance here to the research topic, given the early theme of young people being perceived as 'difficult to communicate with'. This approach to understanding the clinical relationship was first described by Balint, (1961) and was discussed earlier under the section *Competing epistemological frameworks in general practice.*

The Triadic consultation

The corpus of published literature which focuses specifically on young people consulting with a third party is slim. A literature review which aimed to look at the evidence on both the degree, and the form of involvement, which younger patients have in their primary care consultations, excluded those over 12 years of age (Cahill and Papageorgiou, 2007).

A recent French study undertook a comparative analysis of adolescents consulting their GP accompanied or alone, using self-administered questionnaires completed before and after consulting, and involved 674 young people and 53 GPs (Binder et al., 2010). They found that young people consulting alone spoke more of their 'personal worries' and were most satisfied with this mode of consulting, above others. The authors also found that the GPs and the accompanying parents differed in their assessment of the consultation, although they report that they tended to converge following the conclusion of the consultation. Adult accompaniers 'over-estimated the adolescents' well-being and freedom to talk', while GPs 'under-estimated their well-being, readiness to confide and feelings of being understood'. The authors argue that 'GPs could be more optimistic about adolescent consultations', referring to both situations of young people being seen alone or accompanied.

Data in the grey literature (Young Minds, 2011,Lamb and Poynton, 2012) suggests that young people prefer to consult when accompanied by their friends, rather than family. No published data was found to support this position.

Therapeutic relationships in the consultation

GPs and mentalization

The early work of Michael Balint, the Hungarian psychoanalyst who is credited with first writing about psychodynamic aspects of 'the doctor-patient relationship' (Balint, 1957) is a critical player in a literature review which considers therapeutic relationships in general practice. His work continues to underpin some of the more recent developments in understanding the processes which may operate in a clinical consultation. The literature search investigating how GPs respond to emotional distress in adults revealed a paper from Denmark which studied how GPs respond to patients' psychological problems (Davidsen, 2009) and proposed a theoretical framework based on the psychodynamic concept of *mentalization.*

This concept is essentially a reflective activity (Fonagy et al., 2002) which builds on Balint's ideas and is informed by insights from interpersonal

psychology (Fonagy, 1991)and the newer psychotherapies which draw on the attachment tradition and on psychoanalytical developmental theory (Mitchell, 1999). Allen & Fonagy, (2006) propose that '*mentalization* refers to the ability to make sense and understand other people's minds and behaviour as a result of their mental state and furthermore to understand one's own feelings and reactions towards the person'.

Mentalization is considered a precondition for empathy (Allan and Fonagy, 2006) which is described as:

> *a basic component of all healthy relationships ...and considered a core aspect of effective therapeutic consultations in general practice.* (Mercer and Reynolds, 2002)

In this defining paper, the authors describe how empathy is both a (complex) process and a construct (ibid: S10). They advance Morse's model, based on an extensive review of the literature, which defines empathy as a professional interaction composed of four components: the emotive, moral, cognitive and behavioural (Morse et al., 1992).

Davidsen's study sought to conceptualize the processes GPs used when they offered 'talking therapy' (which is funded under present arrangements in Denmark) to adults in primary care. Using a qualitative methodology based on an interpretative phenomenological analysis 14 Danish GPs were recruited. The author reports that the concept of *mentalization* was found useful to conceptualize participants' 'different attitudes to the process of understanding patients with emotional problems' (ibid: 204). After data analysis, five GPs were regarded as practising as 'mentalizing GPs' . This small group of GPs displayed a rich awareness of patients' stories, replete with contextual details and chronological histories. Davidsen describes how the mentalizing GPs demonstrated

> *a propensity to express empathic involvement in the patient's situation and in expressing their thoughts...about the patient's mental state.* (2009: 204)

They also offered a detailed description about their own emotional and physical responses to patients' narratives for example feeling "weighted down" and their work being "heavier and more oppressive" yet more "meaningful".

Six of the participating GPs were considered to be partially mentalizing when the presenting problem was 'obviously emotional' and the consultation could address 'concrete areas such as "work and family situation"'; and three GPs were considered as 'disengaged'. The middle group or the partial 'mentalizers' shifted depending on how interested they were in the patient and their story, with the less mentalizing tending to disengage 'when they could no longer decode any biomedical diagnostic material from the story' (2009: 208).

'Holding' relationships

Continuing to mine the seam of the literature which looked at how the clinical relationship might be therapeutic, a search using the terms: 'containment'; 'containing'; 'therapeutic relationships'; 'pastoral care' identified a small number of studies which looked at 'holding relationships'. Cocksedge has described 'holding work' as

> *establishing and maintaining a trusting, reliable, constant doctor-patient relationship, providing ongoing support without expectation of cure.* (Cocksedge et al., 2011: 485)

The author speaks of such relationships as *pastoral* and sees them as most helpful for patients 'suffering chronic illness, loss and bereavement and relationship difficulties ...and mental health problems ' (Cocksedge and May, 2005: 159). In this paper he classifies three forms of holding relationships: 'continuous long-term' (regular clinical encounters over years); 'episodic long-term' (encounters which cluster around exacerbations of chronic illness or depressive episodes) and 'interim holding' (regular contact over a period of months) (2005:159-60).

The paper articulates the tension in a secular society of finding an appropriate *confidante* or professional contact in the face of 'diffuse

psychosocial problems' which are often themselves a consequence of chronic health problems or relationship fission. Cocksedge describes the uncertainty some GPs feel about *holding relationships* 'as based in a sense of uncertainty about their own competence and about the outcome'. However for those GPs who did engage (from the 23 participants he interviewed) 'experience and common sense' were 'the main tools for this pastoral role'.

The management of emotional distress in adults

Background

Current convention defines mental disorder by the consistency between a patient's reported symptoms and any observable signs, and their match to a psychiatric disorder classification system. Clinical diagnosis attributes a 'label' to the patient's distress but it does not indicate the degree or quality of the emotional distress which inevitably accompanies the majority of psychiatric diagnoses.

The concept of distress has not necessarily been formally recognized in routine clinical practice in general practise, that is to say, in the tradition of 'taking a history' to establish a diagnosis and in the clinical recording of symptoms. This is in much the same way that functional and social impairment has also not been rigorously examined and recorded, leading to a paucity of our 'social and cultural understanding of patients' problems' (Dowrick, 2009b). A model proposed by WHO and WONCA (the World Organization of Family Doctors) (WONCA, 2008) provides a useful tool in describing an emotional-based diagnostic pyramid see Figure 1 below. The base represents day-to-day emotional distress associated with any or all causes and the apex represents the severe end of the spectrum, including experiences of psychotic illness.
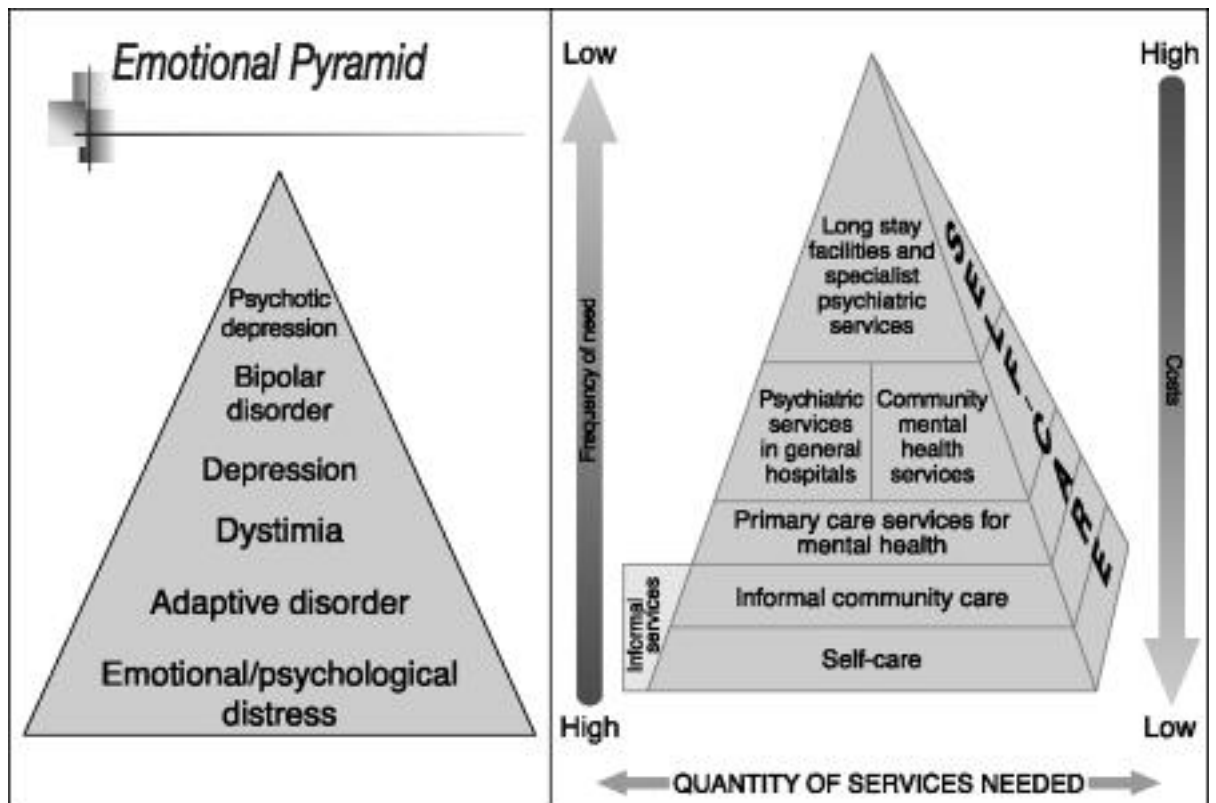
Figure 1: The emotional pyramid and WHO-WONCA pyramid of health
access (WHO and World Organization of Family Doctors (Wonca), 2008)

Whilst this model had broad applicability across all age ranges it has particular relevance to adolescents whose lived emotional distress is usually secondary to psychosocial problems rather than a bounded psychiatric disorder according to the recognized ICD-10 (WHO, 2007) or DSM (American Psychiatric Association, 2005) classification tools. The inclusive term of 'emotional distress' refers to presentations of psychological problems, from their early and undifferentiated stages, to more enduring and severe psychiatric conditions, and offers itself as a useful conceptualization for the research topic and methodology of this thesis.

Furthermore, there is an additional challenge when considering the diagnostic systems commonly used which diminishes their relevance in adolescence. Given the current and expanding understanding of the neurobiology of the brain, it is accepted that there is a period of plasticity which extends until early adulthood when neurodevelopment is considered complete (Gogtay et al., 2004, Rapoport and Gogtay, 2008). This makes

fixed predictions about prognosis, or assignment to diagnostic categories, at best speculative or at worst may lead to a self-fulfilling determinism whereby a young person's distress is 'shaped' to conform to the 'diagnosed' mental health disorder.

This had led proponents of a specialist youth focused mental health service, including McGorry and others, to argue that 'in youth mental health where new and evolving syndromal patterns are the norm' using a rigid diagnostic system impedes 'the search for neurobiological and psychosocial risk factors' (McGorry et al., 2007b). In a debate which sits outside the scope of this chapter the authors begin to critique why the adoption of

> *diagnostic concepts typically derived from sample of patients with chronic illness in tertiary care settings where the impression of stability and validity is enhanced. (*ibid: S40*)*

ill-serves young people whose biological and social landscapes are in transition until early adulthood. There are however opposing voices to this argument who see an age specific model as leading to fragmented care and creating increased competition for limited funding; with a likely commensurate decline in generic clinical skills for practitioners working across the 0-18 year old age range (Birleson, 2009).

GP perspectives on managing emotional distress in general practice

In seeking to understand how GPs respond to the emotional distress expressed by younger patients a review of the literature pertaining to adult patients was undertaken. GPs treat more than 90% of mental health distress in primary care for their adult populations (Goldberg and Huxley, 1992). It is a myth to suggest that mental illness is the exclusive business of specialized mental health services with the majority seen in general practice (Jenkins et al., 2002, Tomson and Shiers, 2003). GP involvement frequently involves some form of psychological management (Cape et al., 2000a, Cape et al., 2000b).

However, in general, the focus of research has been less about what happens at a theoretical level and more an emphasis on 'the doctor-patient relationship' (Mead & Bower, 2002):

> *there is less empirical research into GPs' psychological treatment of patients with emotional problems.* (Davidsen, 2009:200)

Latterly, the impact of the QOF on the everyday management of mental health problems has come under scrutiny (Kendrick et al., 2009 , Dowrick et al., 2009 , Mitchell et al., 2011).

Studies from the last ten to fifteen years have identified a trend in practice which lead to a narrative, based on the research findings, that contemporaneous clinical practice appeared to pay little attention to the social aspects of emotional distress in adults and by implication considered such dimensions to be outside of the remit of routine GP care. Studies contributing to this conclusion include a paper by Armstrong and Earnshaw (Armstrong and Earnshaw, 2004) based on data from a cross-sectional survey designed to assess which items from the GHQ-28 best predicted GPs' assessments of the degree of psychological disturbance experienced by patients . They found that items from the subscales of 'anxiety and insomnia' and 'severe depression' sub-scales were prioritized and items which sought to measure 'somatic' and 'social dysfunction' were ignored by practitioners. This finding was supported by Dowrick and May's empirical study (Dowrick et al., 1996) of 'the rhetoric or reality of the biopsychosocial model' which found that doctors considered social issues (identified as housing, welfare rights, spiritual and political issues) as 'highly inappropriate for a general practitioner to manage'(1996: 106). [This study is referred to earlier in this chapter under the section 'C*ompeting Epistemological Frameworks*].

In contrast, Chew-Graham et al (Chew-Graham et al., 2000) presented a model which suggested that GPs responded pragmatically to 'depression' as a 'a common and normal response to socio-economic disadvantage'. In a study, which recruited GPs working in an inner-city setting, and aimed to

explore GPs' attitudes to patients with depression, the authors found that GPs made an explicit link between socio-economic deprivation and 'depression'. The GPs saw the consequence of multiple stressors such as 'family breakdown, unemployment and underemployment , crime and poor housing (2000: 138) as causal and 'depression' 'a normal response' to 'existential despair'. The authors observed that a GP diagnosis of depression was considered to confer a degree of 'secondary gain' to both parties but at the same time 'depressed people' were seen as 'an intractable interactional problem' for the GP. They concluded that depression was conceptualized as 'an everyday problem of practice rather than as an objective diagnostic category'.

This view of social contexts as contributing directly to 'mental health' marks a (slow) trend towards GPs recognizing the importance of contextualizing distress to an extent which was not evident in studies dating from the previous decade. More recent studies suggest that practice may be changing with doctors becoming more aware of the influence of social adversity on mood and functioning in a way that begins to transcend the limited reductionist biomedical view of 'depression as disease'. Such studies are interrogating previously held uncritical positions which viewed GPs as either poor at detection or treatment of depression (or both). An international study suggests that an explanation of the low rates of

> ... *guideline concordant care is that patients and physicians doubt*
> *the efficacy of technical treatments for depressions that are social*
> *in origin.* (Karasz et al., 2012: e55)

The authors of this paper concluded that many patients do not subscribe to the biomedical model of depression but see their low mood as a consequence of social problems.

In a similar vein, parallel work which prioritizes the patient perspective in order to better understand why the majority of patients discontinue antidepressant treatment earlier than prescribed, would attest to the conflicting ontological positions taken by (some) doctors and (some) patients (Schofield et al., 2011).

However a recent systematic review (Barley et al., 2011) designed to identify 'clinician perceived barriers to and facilitators for good depression care'. The authors 'found that GPs and Practice Nurses continue to remain unsure of the exact nature of the relationship between mood and social problems and of their role in managing it'.

> *Among some clinicians, ambivalent attitudes to working with depressed people, a lack of confidence, the use of a limited number of management options and a belief that a diagnosis of depression is stigmatising complicate the management of depression* (2011).

Others have interrogated the popular adoption of 'stigma' as a rationale for the low rates of disclosure of emotional problems in primary care and found it wanting (Prior et al., 2003). Prior and colleagues postulate that it is the contrasting ontological positions GPs and patients take, with regard to the causes underpinning a low mood, which inhibits disclosure; and the populist adoption of 'stigma' as a rationale is unsubstantiated when subject to empirical research.

The literature review exploring how GPs manage emotional distress in adult patients' presents a clinical picture of a profession which is moving slowly towards accepting the interplay of social factors upon daily functioning and mood, in its adult populations. This is an important trend, as understanding the psychosocial determinants for emotional distress and mental health problems in young people are key. If GPs are now beginning to take this perspective into account for adults, this may translate into an improved sensitivity of their response to young people.

Young people's mental health

A global perspective

Whilst the majority of young people navigate their way successfully through adolescence into early adulthood a significant number experience mental health problems or mental disorders. Rutter et al defined psychiatric disorder as

an emotional disorder in a child or adolescent that has been
present for at least three months and has caused distress to the
child and/or the family and/or the child's environment .(Rutter and
Taylor, 2002)

Mental health disorders in the age group 12-24 years have been called a
global 'public-health challenge' (Patel et al., 2007). The authors identified a
set of community epidemiological studies undertaken since 1995 to establish
'bench-mark' figures for the prevalence rates of mental disorders in young
people and concluded at least one out of every four to five young people in
the general population worldwide will suffer from at least one mental disorder
in any given year. In addition five out of the ten leading causes of Disability
Adjusted Life Years (DALY) of people aged 15-44 yrs are mental disorders
(idem). Such statistics have given rise to a view that mental health disorders
in young people are 'the chronic diseases of the young' (Insel and Fenton,
2005).

In the UK the most recent national epidemiological community survey,
conducted in school settings, found the prevalence of mental health
problems to be 10% of all 5-15 yr olds, (Office for National Statistics, 2005) .
The study was due to be repeated in 2010 but has been postponed by the
Coalition Government (Coleman et al., 2011): 92). A commissioned report
recorded 14% of 16-19 year olds living in private households as having a
diagnosable mental health disorder (Singleton et al., 2001). Data
documenting whether there has been an increase in mental health disorders
in young people is inconclusive because of the absence of national data
sets. Important by-proxy measures include rates of self-harm which appear
stable at around 10 % and youth suicide rates, both of which share similar
risk factors. The latter, having increased between the 1960s to the 1980s,
has since declined since the 1990s, especially in male youth (aged 15-24
years) (Hawton et al., 2012).

International studies report higher rates of prevalence in community samples.
Population based studies from Australia estimate that one in four young
people in Australia will suffer from a common mental health disorder, most

commonly a 'depressive' or 'anxiety disorder', or a substance misuse problem; or a combination of all three (Australian Institute of Health and Welfare, 2003). In the US a large epidemiological study has estimated that 75% of the major mental health problems seen in adulthood will have been present since the early teens, with a peak prevalence in the early 20s (Kessler et al., 2005) .

Adolescence represents a period of transition of

> *exquisite developmental sensitivity, where physical , social and vocational pathways and independence are being laid down.*
> (McGorry et al., 2007a: S5)

It is during this period of constant change in which all aspects of a young person's life are in flux, from their biology to their biographical narrative and social landscape, that mental health difficulties often first present. The complex matrix of genetic inheritance, genealogy, the social context of the family and the local environment, and wider historic-socio-economic factors mean that an attempt to distinguish between a psycho-social history from a biological assessment is futile since all influences play a role and all must be taken into account.

Although there is substantive evidence to demonstrate that adult diagnoses of mental health problems first present in adolescence, detection rates in the decade of peak incidence are low. Kessler et al present data showing that young people experiencing anxiety and depression report delays of 5-15 year before the problem is identified and care offered (ibid). During this 'waste-land' period where young people's mental health needs appear 'invisible' to primary health care practitioners, episodes of low mood and or anxiety are likely to be recurrent and other co-existing mental health problems likely to be persistent. Limited data suggests 30% of first depressive episodes in young people persist beyond 18 months (Goodyer et al., 2003, Gledhill and Garralda, 2011).

Co-morbidity in adolescence, where two or more co-existing mental health problems are present, is considered to be the norm rather than the exception

(Goodyer and Cooper, 1993). Concurrent symptoms of anxiety and behavioural disturbances are present in almost all those diagnosed with a mental health problem; between 50-80% of depressed cases will also meet the criteria for another non-depressive disorder (Mitchell et al., 1988, Goodyer and Cooper, 1993, Herbert et al., 1996).

Young people's mental health in General Practice

The policy context

In the UK, the National Service Framework, the National Institute for Health and Clinical Excellence (NICE) and the National CAMHS Review have all identified primary care as a key setting to address child and adolescent mental health problems (Vallance et al., 2011).

The National Service Framework (2004) was a landmark document in terms of policy direction and promoted the role of primary care staff in the prompt assessment and early intervention of common mental health problems. It succeeded 'Every Child Matters' (Department for Education and Skills, 2002) a key policy document, which set out the commitment of the UK government (at that time) to children and young people's welfare. The ideas and commitment behind 'Every Child Matters' built into the Healthy Child Programme (Department of Health, 2009) which supports the health of all 5-19 year olds. More recently, the role of GPs, and other frontline health professionals, in promoting emotional resilience through early intervention was described in the policy document : *Early intervention: Securing good outcomes for all children and young people* (Department of Health, 2010b).

However, government support for general practice has tended to be 'rhetorical rather than real'. In 2011 the increasing access to psychological therapies was extended to include children and young people but in contrast to services for adults where substantive new posts were created, the services for children have been within existing CAMHS services and are more about 'up skilling' existing staff in standardized forms of psychological therapy rather than increasing GPs' options for referral. CAMHS budgets have also been reduced (Brennan, 2012) and many front line staff who work with children and young people in the community such as parent-support

advisors and local authority funded counselling services have been terminated.

A review of services provided by the NHS for children and young people, conducted by Sir Ian Kennedy (Kennedy, 2010) was critical of the historical focus on providing acute services for children and young people; with less emphasis on (mental) health promotion. The author suggested good care needs to be 'underpinned by anticipatory care and better integration of services'. Kennedy took 'the cultural context 'as his framework and

> *uncovered many cultural barriers standing in the way of improving services which operate at a number of levels from Whitehall.....to regional and local organizations..... to professionals and carers.* (2010: 4)

Detection of emotional distress in young people by GPs

Academics writing from within both general practice and psychiatry agree that adolescent mental health is complex in its presentation.

> *The majority of children and young people with mental health difficulties do not neatly fall into a single diagnostic category. Neither do they present with well-circumscribed symptoms and signs. Some of the most important features in terms of assessment may be concealed or hidden.* (Churchill, 2008)

Michaud and Fombonne assert that

> *The identification, treatment, and follow up of mental health problems in young people can be complicated. Parents and teachers may dismiss problems as merely reflecting adolescent turmoil. Young people are often very reluctant to seek help, owing to developmental needs about being "normal" at the time when they are exploring identity issues and trying to engage with a peer group.* (Michaud and Fombonne, 2005)

Young people who consult their GP represent a particular sub-set of 12-18 year olds. Studies have consistently shown that psychological morbidity

amongst those who seek medical help in this age group is higher than that found in community samples. Research from both the UK and Australia report a prevalence of mental disorders from young people who access primary care as high as 30-40% (Kramer and Garralda, 2000, Ustan and Sartorius, 1995, Mckelvey et al., 2001, Hickie et al., 2007)

However, despite the morbidity associated with psychological difficulties the majority of primary care presentations by young people appear to be for a 'physical complaint', typically respiratory or dermatological problems; with only 2% presenting directly with behavioural or emotional difficulties (Kramer and Garralda, 1998, Gledhill et al., 2003, Tylee et al., 2007).

Data which measures overt presentations of mental health problems and co-existing emotional distress is scant (Coleman et al., 2011).

Despite these high rates of prevalence detection rates of emotional distress amongst young people remain low in general practice. Studies from the UK and the USA estimate that as many as 75% of children and young people experiencing a mood disorder remain undetected (Andrews et al., 2002), (Coyle et al., 2003). A key study conducted in the late 1990s by two London child and adolescent psychiatrists assessed GP sensitivity in identifying psychological distress as 21% (using 'the psychiatric interview' to define 'caseness') and a GP specificity of 91%; which is to say the GPs did not miss the small group of severely functionally impaired teenagers who presented to them (Kramer and Garralda, 1998)

GPs appear to have greater difficulty in identifying mental disorder in young people than in older age groups (Raine et al., 2000). A UK study which looked at GP detection of mental health disorders in 5-11 year olds reported 74% as not being recognised by the participating GPs. This study highlighted the value of parents expressing their concern since it raised GP awareness and improved recognition rates. However only a third of parents felt able to express their concerns in the consultation hence the authors call for parental psycho-education (Sayal and Taylor, 2004).

A similar picture is reported from Australia. Hickie and colleagues analyzed data from two nationwide GP clinical audits and found that whilst mental health problems were common, GPs only diagnosed about half of the patients with 'syndromal conditions' (those which are not severe but sufficiently compromising to meet diagnostic criteria) (Hickie et al., 2007).

Consequently the picture which emerges is one of emotional distress being 'hidden' and not 'seen' by GPs. The discrepancy between young people's 'invisible' heath needs and GPs' difficulties in diagnosis or identification is significant on two counts. Firstly, the manifestations of early mental health problems are not being detected in a timely fashion and allowing for early interventions, which may positively impact on the long term chronicity (Goodman et al., 2002, Allen et al., 2007). Secondly, young people with poor mental health also experience poorer physical health (Office for National Statistics, 2005). This is in part because of the profile of 'risky health behaviours' (a term which can infer deliberate and conscious choices) which is associated with adolescent mental ill-health. Such a profile includes higher rates of unprotected intercourse, alcohol and substance misuse, cigarette smoking and unhealthy eating habits but it also reflects the social determinants of health and the social gradients of mental health problems (Marmot, 2010, Viner et al., 2012).

Without entering into a complex and critical debate about how this situation arises and interrogating the bi-directional influence of causal factors which both trigger and compound poor emotional health , this constellation of risky behaviour will rarely be addressed if the associated mental health problems are not identified. Given the low rates of GP detection reported in the literature this would appear to be the current picture in the context of general practice today.

Patterns of attendance for young people in primary care

One explanation for low detection rates may sit with a view that young people have low rates of attendance in general practice. This is not supported by the evidence. Recent data from the UK Q Research Database shows a conformity to a minimum, base-line attendance rate of two

consultations per annum which has been reported in a number of studies see (Tylee et al., 2007, Hippersley-Cox and Vinogradova, 2009). The most recent statistics derived from this data base, collated in Key Data on Adolescence (Coleman et al., 2011: 39) demonstrate stable trends of frequent consultation rates among young people.

The figures show a relatively stable rate of consultation since the mid-1990s, with a continued small upward trend from 2004. There are also consistent gender-based patterns seen in the data. In summary, male consultation patterns remain relatively constant at around two consultations per year and only increase slightly during late adolescence. Among young women, however, late adolescence (15-19 years) marks a dramatic increase rates to an average of 4.5 per year, with a further increase to 5.5 consultations per year by age 20-24. Furthermore, an additional study (Balding and Regis, 2010) found that around half of school pupils in Year 10 (aged 14-15) had visited their GP in the three months preceding the survey. The authors also report on teenagers' experience of talking to their GP: nearly a quarter of girls (23%) reported feeling 'quite uneasy' or 'very uneasy' with their doctor on their last visit (cited in (Coleman et al., 2011: 40).

Education and training for GPs in adolescent mental health

The role of education and further training has consistently been advocated as a means of addressing GPs' difficulties in identifying mental health problems in young people and to increase their confidence in this clinical arena. The results have been mixed. Haller and others (Haller et al., 2009) report a study which looked at how young people's emotional distress might be identified in general practice. They assert that 'even highly trained GPs fail to recognize 50% of their young patients' distress', citing studies from both Australia and the UK (McKelvey et al., 2001, Gledhill et al., 2003, Hickie et al., 2007).

Others have proposed that training at postgraduate level can improve practitioner performance and confidence. Bernard et al delivered a short programme for GP Registrars to improve their detection and management of common mental health problems in children and adolescents which was

reported as demonstrating an improvement when pre and post intervention scores were compared (Bernard et al., 1999). In Australia, during the late 1990s, a multi-layered educational initiative was delivered to self-selecting GPs, based around a six week programme involving didactic and small group learning, role plays and case studies and was subjected to a randomized controlled trial (RCT). Baseline scores were followed up at seven and 13 months and it was reported that for the 108 participating GPs knowledge, skill, perceived competency and self reported change in practice had all improved (Sanci et al., 2000). The structure of this educational programme has since become embedded in the Royal Australian College General Practitioner curriculum.

Finally, the most recent development has been in the area of 'e-learning' programmes. Most notable in this field is the e-learning Adolescent Health Project (Department of Health, 2010a) sponsored by the Department of Health and led by the RCPCH with input from the RCGP. It is a 72 session self-directed learning programme available to all NHS staff, aiming to build capacity through individual learning and professional development. No data is currently available to indicate the take-up rate by clinicians (personal communication, Churchill, 2011).

Below the multiple perspectives of young people, their families and GPs will be discussed in turn in relation to the supporting literature.

Managing adolescent emotional distress in general practice:

Young people's perspectives

There is a growing corpus of both published and grey literature which seeks to understand young people's views and their practices around help-seeking behaviour associated with emotional distress. A range of international (Rickwood et al., 2007) and UK based studies (Biddle et al., 2006) attest to the reluctance of adolescents to ask for professional mental health care and of the complexity of the factors involved in health-seeking behaviour . Much of the reluctance to seek help and risk the exposure of oneself has been documented in studies of adults (Tait, 2009) but there are specific features

pertaining to adolescence which may dissuade a young person from seeking help from their GP.

These include embarrassment at discussing personal problems (Churchill et al., 2000); concern about whether confidentiality will be respected (Ford et al., 1999), insufficient time in the consultation (Jacobson et al., 1994), (Churchill et al., 2000); a belief amongst young people that individuals should be responsible for resolving their own problems and that GPs are not regarded as a useful source of help; young people holding negative views regarding GPs' likely range of responses (Biddle et al., 2006); an unrecognized need for mental health support amongst young people (Bushnell et al., 2005) and a belief that GPs are not interested in emotional problems (Biddle et al., 2006, Tait, 2009).

The Biddle et al study (2006) offers an important insight into the perceptions of young people regarding GPs and the management of emotional distress in primary care. 23 young people (aged between 16-24 years) who had scored above an accepted cut-off on the GHQ were interviewed about their decisions to consult a GP or not. The authors found that this patient group appeared to view GPs as neither interested nor knowledgeable about mental health problems, keen to prescribe psychotropic medication if they suspected a mental health problem and to seek physical explanations for symptoms of distress. Such views resulted in many of the young people interviewed declaring they would prefer not to disclose their inner emotional worlds to a GP, with some of the participants choosing self-harm as a preferred means of coping rather than consulting with a GP.

A number of other studies conducted around the same time were designed to interrogate 'the consultation', both in terms of its content and pattern, to explore young people's use of general practice. A study by Martinez et al (Martinez et al., 2006) found a theme of 'mutual reluctance' on the part of both the GP and the young person to openly explore psychological issues. The study, based in semi-rural Norfolk, looked at 98 adolescents; 31 of whom were found to be suffering with psychological difficulties (using the self reported Strength and Difficulties Questionnaire); only 19 of whom were

identified by the GP. Of those 19 identified, only seven were offered a management plan. The authors conclude that unless emotional issues are raised in the consultation mental health problems are very unlikely to be considered by the GPs who do not explore emotional issues even when they are perceived to be present.

Informed by this work, a more recent study, which provided a detailed description of the factors associated with GP's identification of emotional distress in young people (aged 16-24 years) suggested that if young people could 'acquire a better perception of the significance of their symptoms of emotional distress at a preclinical level then 'improved recognition in primary care would be expected' (Haller et al., 2009). This paper, which suggested that the GP interview style may be influential (but did not explore this in the study), concluded that young people's own health beliefs were important in determining whether help was sought.

Adding to our understanding of young people's help-seeking behaviour Mauerhofer and others (Mauerhofer et al., 2009) looked at the differences between 16-20 year olds who sought help for psychological problems and those who had not. They found that 'older' young people, those who were a student, and those who had a history of a suicide attempt were linked to higher rates of disclosure. In a large cross-sectional study (N = 7,429) they concluded that the 'majority of young people reporting psychological problems (in a survey) do not seek help, although they regularly consult their GP'.

In contrast, UK based researchers have looked at the impact of GPs showing an interest in young people and extending their gaze beyond physical symptoms. Ferrin and colleagues (Ferrin et al., 2009) used a case-control study design to determine what factors might encourage a young person with depressive symptoms to consult a GP; as opposed to one scoring similarly low on the 'Mood Feelings Questionnaire' (Angold et al., 1987) who did not choose to see a GP. The authors found that where a young person believed that GPs were interested in 'mood and feelings' and 'health problems' and not just physical complaints; coupled with certain

demographic details (a lower socio-economic status, 'non-White' and living in a 'non-intact family') they were more likely to consult their GP .The group most likely to consult were young black women from 'non-intact' families. The design of the study did not permit an exploration of why these associations might arise. The authors concluded that 'both socio-demographic factors and adolescent attitudes influence general practitioner attendance in adolescents with high levels of depressive symptoms' (2009: 32).

 A comparable study from the USA (Byczkowski et al., 2010),which was designed to measure patient satisfaction and to explore and compare the experiences of care between parents and adolescents in a paediatric primary care setting, reported that the young people interviewed particularly valued practitioners' communication skills, as well as their respect.

Within the grey literature there is accumulating evidence which prioritizes the young person's voice and uses a person centred approach to explore what young people want from healthcare services. A report from the Mental Health Foundation (Mental Health Foundation, 2007) based on a six year inquiry into the factors affecting child and adolescent mental health produced a user centred 'wish-list' which proposed a major structural re-organization of service delivery if the current situation is to change. Within this structural overhaul the role of the GP was examined and there was a desire expressed 'to build a rapport with a healthcare provider who could guide them through services, demonstrate greater sensitivity from service professionals in times of crisis and provide alternatives to medication'.

Young peoples' families' perspectives

Exploring the family context is also critical if young people's views are to be examined. Ideas about how a GP operates and what it is legitimate to discuss in a consultation do not arise in a vacuum and adolescents develop their own views in part influenced by earlier experiences of consulting as a child and of listening and observing how their family and peers discuss consulting behaviour. A recent study (Sayal et al., 2010) explored the factors influencing parental help-seeking for children and young people with

emotional or behavioural difficulties; using focus groups of invited parents, each of whom had a child aged up 17 years old. The authors concluded that

> *parents place a high value on GP interest in the child and family situation and GP behaviour demonstrating that they listen to and take their concerns seriously, rather than on the need for specific expertise in the area of child and adolescent mental health.* (2010: 480)

This study provides evidence of what parents would like for their children from the GP, and demonstrates the importance of empathic listening which does not aim to 'solve' problems. The study also reported that short appointments were a barrier to parents raising concerns about their child's emotional health as they 'did not allow sufficient time to address their child's difficulties'. Disruptions to providing continuity of care and the building of trusting patient-doctors relationships were also signalled out by parents as substantial barriers to sharing concerns.

GPs' perspectives

Much less is known about the GP's perspective when consulting with young people experiencing emotional distress. There is a (small) evidence base that self-reported confidence in knowledge and attitudes towards adolescent mental health care amongst GPs is poor (Cockburn and Bernard, 2004). The authors of this questionnaire study found that the majority of GPs rated as 'less than satisfactory' their competence, knowledge and skills in child and adolescent mental health practice. An earlier Australian study (Veit et al., 1995) found that 80% of 1,000 surveyed GPs reported inadequate undergraduate training in this area and 87% would seek opportunities for continuing professional development in this field.

In conjunction with a lack of confidence around their clinical knowledge there may be other reasons as to why the identification of psychological problems in young people poses particular difficulties for GPs; despite an observational finding that GPs perceive an increase in adolescent depressive presentations (Vandana and Ambelas, 2004). Shorter consultations will compound a challenging clinical presentation and there is some limited

evidence that this is the case (Jacobson et al., 2002). A collective fear of 'over-medicalising' young people's lives has been expressed (MacFarlane and McPherson, 1995) and there is a view, often quoted, that young people do not engage with psychological therapies. Historically this view appears to be based on a study of 14 teenagers who demonstrated low attendance rates when offered psychological therapy in their local surgery (Westman and Garralda, 1996).

Further afield two child psychiatrists in Norway looked at the variation in clinical practice amongst GPs referring to their out-patient clinic and conducted a descriptive study based on focus groups of 19 self-selected GPs (Hafting and Garlov, 2009). The authors found that those GPs who did engage with emotionally distressed young people and their families, largely did so in the guise of offering parental counselling and there was little prioritizing of the young person's perspective in their practice . The authors observed that there were few if any personal reflections in the focus groups 'about difficulties or emotional experiences in management of this group of patients' (ibid: 258) which they assume is a desire not to reveal 'incompetence in front of their interviewers'. As a result, the motivated GP participants who agreed to take part all supported the consensus view that GPs are well-placed to offer support to young people and their families but offered no new insights into the potential barriers which prevent GPs from executing this role.

There have been two qualitative studies exploring this complex phenomenon in greater detail from the perspective of the GP; both conducted by Iliffe and colleagues (Illiffe et al., 2008, Illiffe et al., 2012). The first study aimed to explore GPs' perceptions of 'the opportunities and difficulties of working with teenagers and of specifically recognising and responding to depression .It draws upon nine semi-structured interviews with GPs, based in one London practice, which were analysed thematically. The authors found two over-arching themes. Firstly, teenagers were perceived as being 'qualitatively different' from adults in the ways they used general practice and secondly, GPs were uncomfortable in making a diagnosis of depression in young people. They concluded that if routine clinical practice is to change

and GPs are to increase their involvement with young people experiencing emotional distress these two perceptions will need modifying. The authors suggest that subscribing to a view that 'depression' is a 'normal' affective state in this age group needs to be challenged and secondly, 'the perceived under utilization of general practice by teenagers' held by GPs (2008 : 277) will need addressing. The authors conclude that it is a 'GP's knowledge and skills' which appear to most determine the 'recognition and appropriate management of depression' (2008: 277).

The second and most recent study (Illiffe et al., 2012) aimed to test 'the usability, acceptability and usefulness of a technique known as TIDY (the Therapeutic Identification of Depression in Young People) which blends diagnosis with a CBT based psychological intervention in a single consultation in primary care. They interviewed 25 GPs and six nurses and analysed the data using a 'grounded hermeneutic approach' and 'an analytical induction technique' which involved testing initial hypotheses against the empirical data 'particularly for falsifying data' (2012: 134). The authors identified two themes. The first was grouped under 'making sense of teenage depression' and the 'impact of training'; the second theme concerned whether GPs 'owned' or were 'owned by' time. Most GPs reported difficulties using the TIDY technique. The authors single out defining depression and using the word 'depression' with adolescents as the most difficult task discussed by study participants; with time constraints also a dominant theme.

Finally, a recent Dutch study (Zwaanswijk et al., 2011) contributes to this cognate area by concluding that there has been an increase in the frequency of GP identification of mental health problems but this has not been matched with any increase in GP involvement in their care; with the majority of cases continuing to being referred to secondary care.

Chapter Three: Methodology

Introduction

'All research is interpretive'. (Denzin and Lincoln, 2008)

Undertaking qualitative research invokes a complex process which is built upon *'theory, analysis, ontology, epistemology and methodology'* (Denzin and Lincoln, 2008: 28).

This chapter will begin by discussing the ontological and epistemological underpinnings of the thesis which are located within the 'constructivist-interpretive' paradigm.

The interpretavist approach has been selected for its 'best fit' to the nature of this explorative inquiry. The chapter will discuss the theoretical foundation of the study which lies in *symbolic interactionism,* followed by an introduction to the 'theory-methods package' of the research which is described as *situational analysis*, a 'post-modern from of grounded theory' (Clarke, 2005). The core elements of *situational analysis* are to be presented and compared and contrasted to the early form of grounded theory. The first part of the chapter will then conclude with a discussion of the role of reflexivity in constructivist interpretivist research.

The second part of the chapter focuses on how the data was gathered. It will discuss the methods used to gather the empirical materials of the study and the analytical process of *situational analysis*.

Methodology : the theoretical bedrock

Locating the research

Guba proposes that

> *the net which contains the researcher's epistemological, ontological and methodological premises may be termed **a paradigm** or an interpretive framework, a basic set of beliefs that guides action* (Guba, 1990: 17)

All research is guided by the researcher's former experiences and education which shape their beliefs, feelings and attitudes about the world and how they gather and interpret data.

This particular ontological perspective builds on earlier work by Kuhn which contested the accepted convention that scientific knowledge was built upon existing 'building blocks' of knowledge which progressed forwards in a linear fashion (Kuhn, 1962). Kuhn is credited with introducing the idea of paradigm shifts or scientific revolutions in which basic assumptions are challenged by an alternative way of interpreting events and information and can result in a profound change in the way knowledge frameworks are constructed and used.

This can lead to the development of new paradigms which have also been described as referring to

> .. the set of questions, practices and institutional arrangements
> that characterise scientific activity for a particular historical period
> (Bilton et al., 2003).

Interpretive paradigms

> Qualitative research is a situated activity that locates the observer
> in the world. It consists of a set of interpretive, material practices
> that make the world visible. These practices transform the world.
> They turn the world into a series of representations.   (Denzin and
> Lincoln, 2003; Denzin and Lincoln, 2003:4)

The aim of this inquiry was to explore how GPs responded to young people presenting with emotional distress associated with psychological difficulties. The exploratory nature invites a qualitative methodology as it is looking principally at the 'how' and 'why' questions rather than the 'what' question and suggests an interpretive framework.

There are considered to be four major interpretive paradigms which structure qualitative research: positivist and post positivist; constructivist-interpretive; critical (Marxist, emancipatory) and feminist-post structural (Denzin and Lincoln, 2008: 31). All of the paradigms accept the notion of relativist

ontologies (multiple ,constructed realities) and incorporate interpretivist epistemologies, that is to say, the researcher and the participant, using naturalistic methods, influence one another, to generate data. [Positivist qualitative research assumes that there is an apprehendible truth which can be sought by the verification of hypotheses, although it is an approach largely confined to quantative research].

Despite the commonality of the interpretive paradigms 'one cannot move easily between paradigms' (Denzin & Lincoln, 2008: 8) because of their commitment to over arching philosophical axioms of epistemology, ontology and methodology. 'Perspectives, in contrast, are less well-developed and one can move between them more easily' (Denzin & Lincoln, 2008: 8). For this reason, the reader will see the term 'perspective' used more often in the thesis, especially since discussions pertaining to knowledge frameworks, when used by individuals, require a recognition of the fluidity of the frame of reference.

However, having said that, given the exploratory nature of this study it is undeniably located within the constructivist-interpretive paradigm. As such, the research aims to generate a substantive theory which is developed and inductively grounded in the data, and which can be judged upon its trustworthiness, credibility and (theoretical) transferability rather than its validity.

Each of these elements will be discussed in detail in this chapter.

Theoretical Perspectives: Symbolic Interactionism

Locating the study within the interpretivist paradigm demands a particular vantage point

> *Interpretive theory calls for the imaginative understanding of the studied phenomenon. This type of theory assumes emergent, multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual'.* (Charmaz, 2006*:* 126)

This position is consistent with using grounded theory, which is both a theoretical approach and a method, and will be discussed in detail in this chapter. The antecedents to grounded theory lie in *Symbolic Interactionism* , a theoretical perspective which has its intellectual roots in the philosophy of pragmatism and psychological behaviourism (Rock, 1979, Joas, 1985), cited in (Ritzer, 2003: 335) and is associated with George Herbert Mead, considered the intellectual 'grandfather' of *symbolic interactionism.*

Dewey, a key protagonist in philosophical pragmatism and important in Mead's 'developing sociological orientation' (Ritzer, 2003: 335) believed that the mind did not have an objective existence but rather was 'a thinking process that involves a series of stages' (Ritzer, 2003: 335). Dewey's view was that knowledge arises through the action and interaction of self-reflecting beings; and that behaviour is contingent upon context and particular processes , summarized as a 'cultural matrix' (Dewey, 1938). Philosophical pragmatism considered that knowledge is important inasmuch as it informs action, summarized by the aphorism 'what is true is what works' (Denzin in Flick, 2004: 85). This position is equally understood as people behaving in a certain way because of the cultural context in which they find themselves. Language was considered to be pivotal in influencing behaviour.

Psychological behaviourism or 'social behaviourism' to differentiate Mead's position from the radical behaviourism of the time, accepted that whilst the 'stimulus-response' aspect of overt human behaviour was observable, human beings used 'language between stimulus and response in order to decide how to respond' (Ritzer and Goodman 2003: 336). In other words, the ability to use mental processes and be active in 'the act' differentiated people from 'Pavlovian dogs', which had been a dominant view of radical behaviourism held at the time.

Mead took the understanding of the importance of context further and he combined his understanding with *philosophical pragmatism* which held at its centre a belief that 'true reality' is created through action; that people remember and base their knowledge of the world upon what has proved

useful to them; and that social and physical objects are defined according to their use

> *What is true is what works.* (Denzin, 2004: 84)

Mead's (interpreted) view, given that he never published any work, was that the self was socially created and mediated by our everyday life experiences.

> *Self is a social object which lies in the field of experience.* (Denzin, 2004)

Blumer, a pupil of Mead's at the University of Chicago in the 1920s and credited with capturing Mead's ideas in text, developed these emerging social-psychological ideas and coined the term *symbolic interactionism* in 1937 (Blumer, 1937). This sociological orientation prioritised the view of people as actors who construct meaning based on interaction, and disputed a reductionist, mechanistic view of human behaviour including, for example, Freudian theory which saw human behaviour as shaped by unconscious impulses; or the radical behaviourism which effectively equated human behaviour to animal behaviour.

Blumer's later definition of symbolic interactionism developed the earlier ideas of philosophical pragmatism and extended them to include a view that meanings and symbols are both derived from, and open to, modification, based on human interaction through the conscious examination of the consequences of such behaviour. He suggested that it is the intertwined patterns of action and interaction which make up groups and societies; what Blumer calls the 'social life of a human society' (Blumer, 1969a, Blumer, 1969b).

To offer further clarity to an understanding of *symbolic interactionism,* Denzin has written in an elegant summarizing chapter that *symbolic* refers to the role language plays and 'the underlying linguistic foundations of human group life'; and *interaction* refers to human behaviour being in response to the way 'people interact with each other' rather than 'toward one another' (Denzin, 2004: 81-2).

In describing recent developments of this sociological perspective Denzin (2004: 85) suggests that *symbolic interactionism*'s sensitivity to the 'reflexive, gendered, situated nature of human experience' has contributed to a more narrative turn in its recent history. The narratives which symbolic interactionists produce, out of the data they create, can generate explanatory theories of everyday life. These inductively developed theories hinge upon an examination of systems of *discourse* where discourse is understood as a way of representing the world and can include spoken and written text. Thus, symbolic interactionists 'study how narratives, connected to systems of discourse, represent experience' (ibid.). Their work is rooted in the lived experiences of interacting individuals and they tend to reject totalizing grand theories to explain social behaviour, believing in 'local narratives about how people do things together' (ibid: 83).

It was from within this philosophical orientation that the methods for this study were chosen.

Grounded theory

Grounded theory is said to have its intellectual roots within *symbolic interactionism* (Clarke, 2005: 1). This particular methodological approach to data gathering was first created in the 1960s during a period of social turbulence when the status quo in a wide range of settings, including academia, was being challenged and minority views were beginning to be heard. Originally developed in 1967 by Glaser and Strauss (Glaser and Strauss, 1967) the research methodology was aimed at resisting the dominant quantitative approach which dismissed qualitative methodology as subjective and 'unscientific'. It set out to develop a rigorous strategy which would systematically derive theories of human behaviour from empirically gathered data using an inductive line of inquiry. From its inception it has always had a strong presence in health research (Urquhart, 2001).

Grounded theory is aimed at generating theories of complex social phenomenon (Lingard, 2008) by researchers who need to set aside established theoretical ideas from the field of inquiry in order to allow a

substantive theory to emerge; a theory which can then be examined in the light of what is already known.

Charmaz, in her seminal text, *Constructing Grounded Theory* (Charmaz, 2006) has ably defined the core components of grounded theory practice, based on (Glaser and Straus 1967; Glaser, 1978; Strauss, 1987) as the following

1) The simultaneous involvement in data collection and analysis

2) Constructing analytical codes and categories from data, not from preconceived logically deducted hypotheses

3) Using the constant comparative method

4) Advancing theory development during each step of data collection and analysis

5) Memo writing to elaborate categories, specify their properties, define relationships between categories and identify gaps

6) Sampling aimed towards theory construction, not for population representativeness

7) Conducting the (completed) literature review after developing an independent analysis

Using grounded theory, empirical materials are derived through fieldwork, often supplemented by access to documents and other materials and collected using *theoretical sampling*. This will be discussed below in more detail and with relevance to the study in hand. As Charmaz indicates above, data collection and analysis is both simultaneous and iterative as it advances through the process and progresses towards the articulation of emerging categories which are developed through the constant comparative method.

The process continues until no new categories emerge and all of the existing data is considered to fit with the defined categories, in what is known as *theoretical saturation* (Strauss, 1987 ,Glaser, 1992). Grounded theory coding is core to the process and as Charmaz makes vivid, with the expression

> *coding generates the bones of your analysis.* (2006: 45)

It creates a framework from which the analysis is built. The first stage of coding produces the *open codes* which define the analytical territory. Strauss and Corbin define open codes as derived from

> *Breaking data apart and delineating concepts to stand for blocks of raw data.* (Corbin and Strauss, 2008: 195)

These codes effectively scope the terrain but at the same time keep the researcher open to 'all possible theoretical directions' (Charmaz, 2006: 46). Dey further defines open coding as 'a process of identifying categories, properties and dimensions' (Dey, 1999); cited in Urqhart, 2001: 3).

The coding process then moves into a more focused phase where the aim is to develop the most salient categories. This stage requires making

> *decisions about which initial codes make the most analytical sense to categorize the data incisively and completely.* (Charmaz, 2006: 57)

The process of focused coding generates the axial codes (Strauss, 1987) which organize the data into its operant categories and provide axes about which all the gathered data can be organized. Corbin and Strauss define axial coding as a process which involves

> *Crosscutting or relating concepts to each other.* (2008: 195)

and which 'examines the conditions, strategies and consequences' (Dey, 1999) of the emerging themes. Successful axial coding leads to the properties and dimensions of a category being fully articulated (Charmaz, 2006: 60).

The final stage of coding aims to distil the entire corpus of data into a 'selective code' which is the scaffolding of the substantive theory, having been developed out of the data. The selective code articulates the conceptual explanatory framework and draws together the axial codes in an 'emerging storyline' (Dey, 1999).

The early days of grounded theory

At its inception, grounded theory began as a positivist endeavour in pursuit of a 'truth' (Glaser, 1992, see Clarke, 2005:17) supported by the 'naïve' collection of materials by a researcher, untainted by existing ideas in the field of inquiry and subject to *triangulation*; a positivist practice which seeks to verify findings using multiple methods to 'confirm' verisimilitude.

It has since moved away from its early epistemological genesis, having been influenced by the progressive development of ideas within qualitative research, described by Denzin & Lincoln (2008: 19) as 'the eight moments'. This would result in the rupture between Glaser and Straus who very publically adopted subsequently different positions on the notion of grounded theory discovering 'truths' (Glaser, 1992, Urguhart, 2001)), a rupture considered as reflecting *the legitimation crisis* in qualitative research (Denzin and Lincoln, 2008: 26). This constituted a serious re-evaluation of such terms as *validity, generalizability* and *reliability,* concepts which hinged upon whether an objective truth exists or not.

The changing ontology and epistemology of grounded theory also lies in the influence of social constructionist principles which gathered momentum from the late 1960s. In their canonical text *'The social construction of reality'* (1967) the authors Berger and Luckman (Berger and Luckman, 1966) , along with other contemporary scholars, such as Schutz (1967) paved the way 'for a deeper understanding of social reality as a socially constructed and socially distributed phenomenon' (Denzin & Lincoln, 2008: 66).

> *Berger and Luckman argued that our everyday sense of reality is the product of an ongoing negotiation over the meaning[s[of objects, events and actions. In order to understand our construction of the sense of reality, we should....concern ourselves with the processes by which that 'reality system' is produced.* (Bazerman, 1994:115 cited in Clarke, 2005: 149).

Taking on board social constructionist ideas shifted Glaser away from the positivist roots of early grounded theory and contributed to the evolution of *situational analysis* as one of its progeny*.*

Situational analysis

In her elegantly presented and comprehensively argued project '*Situational analysis: grounded theory after the postmodern turn'* (2005) Adele Clark weaves together the philosophical underpinnings of *symbolic interactionism* and its originator, grounded theory, to offer a new theory/methods package known as *Situational Analysis*. Clarke refers her audience to the intellectual roots of *symbolic interactionism* where Mead and other scholars of the Chicago school developed the notion of multiple perspectives being at play in any human act. This gave rise to the theorem

> *Situations defined as real are real in their consequences.* (Clarke, 2005)

which was later substantiated into Berger and Luckman's treatise of social knowledge which articulated *social constructionism* as a concept in its own name, as presented above (Berger and Luckman, 1966). The theoretical perspective of social constructionism has led to *symbolic interactionism* as being understood as

> *a constructionist perspective because it assumes that meanings and obdurate realities are the product of collective processes.* (Charmaz, 2006: 189)

Clarke argues that since

> *grounded theory is a methodology inherently predicated upon a symbolic interactionist theoretical and philosophical ontology'.* (2005: 4)

It is the act of doing grounded theory which makes symbolic interactionism come alive.

The author begins with accepting *a priori* the fundamental tenets of grounded theory and in her seminal book describes how these are taken through the postmodern turn to emerge as a methodology which recognises and incorporates the complexity of *the full situation of inquiry* (2005: xxviii); using data gathering tools which reveal insights gained from postmodern theory. She identifies six elements of grounded theory which are germane to its new form in *situational analysis*

- The Meadian notion of 'perspective (*in which perspectives are socially constructed and nature too is socially constructed)*

- Its materialist social constructionism

- Its foregrounding of analytical interpretation using open coding which encourages multiple simultaneous interpretations

- The orientation towards action, process, negotiation

- The range of variation in the data being acknowledged as always significant

- The longstanding orientation to ecological and social worlds/arenas relational forms of analysis (*or mapping*) (2005: 6).

Having outlined the core components which provide the theoretical bedrock of the new theory/methods project she proposes, Clarke identifies what she call the '*recalcitrancies of traditional grounded theory'* and outlines how her new method will address these 'deficiencies'. The author summarizes the faults or 'deficiencies' of grounded theory as being firstly inadequately reflexive. Traditional grounded theory began from a position of the researcher as 'invisible' which she argues is untenable

> *no longer is self-reflexivity an option.* (Denzin,1996; cited in Clarke, 2005: 11)

It also prioritized an 'over simplification' of analysis with an emphasis on commonalities which in turn led to an interpretation of data variation as being "negative cases", rather than as a finding in their own right. Finally, a

relentless quest for 'purity' and 'truth' was seen in traditional grounded theory which Clarke would assert is incompatible with a postmodern view of the world (Clarke, 2005:11).

Clarke's proposed new model seeks to embrace complexity and contradiction in the data as more representative of the

> *downright messiness of the empirical world.* (2005:15).

In her critique of these 'stumbling blocks' of traditional grounded theory Clarke also addresses the role of professional experience in the area of inquiry and whilst this should never be used as 'data' she presents Corbin's conclusion that

> *experience is an analytical device used to stimulate reflection about the data at hand.* (2005:13*)*

This point will be further developed below when the notion of reflexivity will be discussed below in detail.

In summarizing how situational analysis will be different, yet complementary, to original forms of grounded theory Clarke proposes that the simultaneous "truths" of multiple knowledges must be assumed; that heterogeneity is accepted as the default position, rather than chasing an elusive homogeneity; the pursuit of formal theory is abandoned for the notion of analytical sufficiency of sensitizing concepts; and greater emphasis is put on 'discourse' (be that narrative, visual, historical) to expand our understanding of the domains of social life. In order to draw together all of these new positions Clarke postulated that it is the application of mapping tools which constitutes

> *doing situational analyses throughout the research process.* (Clarke, 2005:19)

and which will make the greatest difference when compared to undertaking conventional grounded theory .

It is the technique of using mapping tools which most succinctly defines *situational analysis*. Clarke offers three main 'cartographic approaches' which enrich the collection of empirical materials during the analysis. These include *situational maps* which lay out the main elements in the research situation of inquiry; *social world/arena maps* which lay out the actors and arenas of discourse and *positional maps* which lay out the major positions taken, and not taken, and illuminate areas of difference, concern and controversy. These mapping tools are influenced by the general framings of ecology and cartography and are presented as

the root metaphors for situational analysis. (2005:10)

They will be discussed in detail below.

The new roots of Situational Analysis

Three 'new roots' are described by Clarke as taking grounded theory through the post modern turn. The first of these is in the elevation of *power* as being of equal importance in human interaction as *action,* which was Strauss and Glaser's original focus. The second of the new roots is the analytical importance of 'non-human' or inanimate actors in the situation of inquiry such as legal constraints and physical structures which influence human interaction and behaviour. Finally, there is the centrality of a multi-layered and contextually rich analysis of the situation which went beyond the ecological models advanced by the Chicago school (of sociology). Each of these influences in Clarke's model of *situational analysis* will be discussed in turn.

I. **Foucault and the interactionist project**

Adele Clarke is a Foucauldian scholar and credits Foucault's influence on her understanding of the influence of power which is seen as being productive rather than always repressive. Foucault challenged the orthodoxy in his canonical text '*Discipline and Punish'* (Foucault, 1975b) where he interrogated the connection between power relations and the formation of scientific knowledge, given that criminology was viewed as a science in the nineteenth century. Foucault's project was to understand "who are we?"

(May, 2006: 2) and he took history as the lens through which, he suggested, we can best understand how we have arrived at our destination, at a given point in time. This position led to the development of his theoretical tool of genealogy; of which

> *the aim is to historicize, in order to radically question the timeless and inevitable character of practices and forms of thinking.*
> (Oksala, 2007: 48)

In short, no human act or practice should be taken for granted. This focus on genealogy led Foucault to examine the history of human practice in a diversity of contexts which included the production of science, governance of a nation and the expression of human sexuality; always within the framework of understanding the relationship between power and the formation of knowledge. He understood all knowledge, including 'scientific truths' as social constructions and their propagation and enactment as a social practice.

Such organized practices require individuals to conform to the power/knowledge networks of a society and is so doing create the identities of participating or, socially recognized individuals ('subjects'). Such individuals must then operate according to the socially created rules of 'the regime of practice' in which they operate.

> *In his view all identities were created through practices of power and knowledge.* (Oksala, 2007: 58)

This ontology extended to all areas of life, moving initially from studying repressive institutions to productive practices with medicine and *biopower* placed under particular scrutiny. He suggests that whilst biopower is presented as being essentially protective of life, bio-scientific knowledge functions as an important instrument of power and supports the socio-political control of people in modern society (Foucault, 1975a).

Clarke (2005: 52) argues that situational analysis is most forcibly taken through the postmodern turn by taking the tenets of grounded theory and subjecting them to a Foucauldian lens. Foucault places power at the heart of

his theorizing; unlike Strauss and Glaser, the original creators of grounded theory, for whom action sits at the centre. From these different but complementary positions both theorists developed a conceptual framework for how life is organized at a social, institutional and structural level. For Strauss this equated to a concept of *negotiated order,* for Foucault this was described as *regimes of practice* (Foucault, 1991).

With reference to the setting of this study general practice exists as an exemplar of a *regime of practice.* Composed of a myriad of activities such as consulting with patients, organizing a system for issuing 'repeat medications' or offering 'healthy heart' check-ups for older patients, *regimes of practice* have at their centre a "universe of discourse" (Strauss, 1978); that is to say, a way of representing the world. Foucault believed that individuals (GPs at work) and collectivities (general practices and their systems of organization) are constituted through discourse and *discipline* by which he means a

> *series of organizing practices that produce the rules through which individuals make themselves up as subjects.* (Dreyfus and Rabinow, 1982: 109).

Rules are both externally imposed, such as 'from the age of 25 years cervical smears are to be taken at three yearly intervals', but, as Foucault was pivotal in exposing, they are also internally imposed as people 'self-police' and accept regulation without question. For example, as seen in patients who request cervical smears to be taken at more frequent intervals because they are fearful of developing cervical cancer.

 Similarly, the rapid internalization of externally imposed systems of regulation might find a parallel with the introduction of the Quality Outcomes Framework (QOF) into general practice. Foucualt's analysis of discipline might offer a useful framework for the debate about how 'the profession' has embedded the QOF structure into everyday practice as if it has always been part of routine practice (Checkland, 2008).

At the centre of discipline is power. Foucault changed the critique of the landscape of medicine when he introduced his idea of "the gaze" to frame

how the doctor looks at his patient in his text *The Birth of the Clinic* (Foucault, 1963)*.*

> *"It is* the *gaze that emanates from a site of power and authority, always already appropriating the right to look and to see, attempting to do so hegemonically, and thereby invisibling/ silencing other perspectives/gazes".* (Clarke, 2005: 58).

Through the medium of the gaze, it is the discursive patterns and dominant narratives which shape the practices defining an institution or social group, such as 'primary care' or 'GP's; through a continual process of conflict and contradiction with competing discourses rarely achieving a consensus.

II. The analytical importance of non-human actors

In the postmodern version of grounded theory Clarke makes explicit the role of 'the non-human' in the situation of inquiry. Since the early days of Strauss and Glaser's vision, the role which material 'things' can play has been incrementally accepted without necessarily being formally acknowledged. Clarke seeks to make this explicit. To simplify, and to present the relevance of this analytical turn, three domains for non-human actors are articulated: the physical; the social; the abstract.

Whilst 'objects are central to collective identities' (Clarke, 2005: 62) it is the specific agency of these three social constructions which exerts an analytical power in situational analysis. Taking each in turn: an example of 'the physical' would be the location and architectural structure of a particular GP practise. For a young person who accesses their general practice surgery the physical elements of the building have a particular potency. A surgery premises which is old, poorly maintained and visually unappealing will exert a different influence and create a different relationship than a surgery which is well maintained, contemporary in style and attractive in appearance.

Exploring what Clarke means by 'the social' means drawing our attention to the roles which are performed in the delivery of general practice. This rotates around the both the performance and the perception of the archetypal roles people play within a practice. Examples might include the 'senior'

receptionist, the 'junior GP partner', the 'part-time' practice manager. How these roles are enacted, and, of equal importance, how they are perceived by the other actors in the situation of inquiry, will contribute to the dynamics of the area under inquiry in this research

Finally, Clarke's notion of 'the abstract' refers to the role which documents, policies, guidelines and more recently, digital technology play in influencing clinical practice. Such "non human actors" exert a significant power in the situation of inquiry and influence behaviour both covertly and overtly, often outside of the conscious examination of the human actors. The landscape of contemporary general practice is populated by a constant stream of externally and internally generated policy documents which shape practice and its practitioners. Any study located within general practice has to take these material objects and their socially determined meanings into account in its analysis.

III. The toolbox of situational analysis: the cartographic approach

Symbolic interactionism was nurtured by the School of Chicago and the school's theoretical attention to social ecologies. This led to the methodologies of the time, such as ethnography, generating relational ecological maps which influenced the subsequent production of Strauss' social worlds/arena maps (Clarke, 2005: 65). These visual depictions of the complex social relationships at work enriched the data collection and iterative analysis, and challenged a wholly linear representation of the data which is the dominant tendency if the analysis priorities a textual format. It is after all easier to represent the 'messiness of the empirical world' (2005:15) through pictorial diagrams and maps.

Clarke examined the antecedents of the cartographic approach, including Corbin and Strauss' conditional matrix (2008), and developed three conceptual tools which form the toolbox of situational analysis. These are known as the *situational maps;* the *social worlds/arena maps* and the *positional maps.* At the heart of their conception was a desire to deconstruct the context in an effort to show how

*the conditions of the situation are **in** the situation. There is no such thing as context* (Clarke, 2005:71).

However, the researcher needs to be able to describe their analysis **and** the intertwined relationship of the findings to the context, within which they are embedded, in a manner which is coherent to the reader and which does not present their findings as if in a 'black box'.

In addition, the use of the new tools as postulated by Clarke offered three 'fresh paths into a full array of data sources' by opening up the data and provoking a deeper analysis (2005: 83). By carrying out analytical exercises using the mapping techniques, the silences of the data are articulated and the direction for the theoretical sampling is illuminated.

In summary, the three tools are firstly*, the situational map*, a loose 'word sheet '(both 'messy' and 'ordered') which needs to include 'all the analytically pertinent human, nonhuman, material, and symbolic discourses or narratives of the situation, as framed by those in it and the analyst' (2005: 87). Secondly, *social worlds/arena maps* offer a meso-level analytical framework in which 'relationships between individuals and as members of social worlds' can be portrayed figuratively. The goal is to open up the data to suggest patterns of collective commitment and to tentatively trace out borders of social worlds (2005:110). Finally, the *positional maps*

lay out most of the major positions taken in the data on major discursive issues therein - topics of focus, concern, and often, but not always, contestation. (2005: 126).

Worked examples of each of these analytical exercises are included in the Appendices and serve as illustrations for each of the three types of map (see Appendix E).

Reflexivity

This first part of the chapter will conclude with a discussion of the role of reflexivity in grounded theory. Reflexivity is defined as

the process of reflecting critically on the self as researcher, the "human as instrument". (Guba and Lincoln, 1981)

A post-modern perspective would contend that all research is interpreted and qualitative research prioritizes this perspective. Within the interpretive paradigm, it is in the gathering and interpretation of the data that meaning is found, and this activity requires the researcher to be cognizant of their own role in the data generation.

There are no innocent positions. (Haraway, 1991)

Traditional grounded theory initially saw the researcher as a detached investigator who could approach the field denuded of theoretical preconceptions and be 'silent'. This, Clarke argues, is a denial of what had earlier been made explicit by Glaser:

*we are, through the very act of research itself, directly in the situation we are studying. (*Glaser, 1992: 50).

Adele Clarke attributes the role of reflexivity as a key player in taking grounded theory through the post modern turn, as was discussed earlier when she accuses traditional grounded theory of making reflexivity 'optional'. Her position comes from a Foucauldian understanding of knowledge which accepts that all knowledge is socially constructed. It also accepts that the researcher will bring 'a constellation of official and unofficial knowledges' (Clarke, 2005: 12) all of which exert an influence on how the data is interpreted.

A reflexive methodology must necessarily include an examination of the self. This is a complex and iterative process, working on a number of parallel strands which involves being both 'in the action' and looking at it from the outside (Schon, 1983). Looking at oneself as a researcher is, in itself, a multiple stranded process; it has been argued that 'the self' in research is a creature of multiple identities (Alcoff and Potter, 1993). Reinharz (1997) argues that the researcher brings three categories of self to the project: research-based selves, brought selves (the selves that historically, socially, personally create our standpoints), and situationally created selves (1997: 3).

Each of these selves has a distinctive voice and contribution to the research project.

It is through the process of rigorous reflexivity that the robustness of qualitative research is assured. Denzin and Lincoln write of 'self-reflexive validity' as

> *a form of critical validity involving paying attention to one's place in the discourses and practices that are being analyzed.* (2008: 566)

As a practising GP and researcher I was conscious of 'slipping in and out' of roles whilst both interviewing and interpreting the data and whilst examining other related materials. Maintaining an awareness of these roles and the different perspectives they invoke was a critical part of the analysis and will be revisited in the Discussion chapter (Chapter Six).

Methods: Gathering the data

The second part of the chapter will describe in detail firstly, the methods employed to gather the empirical data in the research project and secondly, the early stages of the analytical process. The two are not inseparable given the iterative process which underpins grounded theory based on using the constant comparative method. The analytical process will be presented through the discussion of the gathering of the data and of the methods used to produce the empirical materials. This will include a description of the development of the topic guide; the use of theoretical sampling; and the recording of theoretical memos and field notes. Within the nomenclature of grounded theory the early stages of analysis leads into the development of the open codes.

The topic guide

The preparatory stage to data gathering involves designing 'the topic guide' otherwise known as an interview schedule. This needs to be prepared in advance of the recruitment of any participants to the study and was also presented at the time of requesting ethical approval (which was granted in October 2008). The study was described by the ethics committee as being

'well presented ...and an important area for general practice research'
(Appendix A).

Convention advocates a topic guide works best when it concentrates on four
or five key areas allowing for free expression within those domains. The idea
of identifying key areas to be addressed in the interview correlates with
Blumer's notion of 'sensitizing concepts' (Blumer, 1969b) which guides
grounded theorists to begin their studies with certain research interests and a
set of general concepts, rather than to approach the field naively. The
articulation of the concepts addressed in the topic guide indicates a
researcher's general familiarity with the territory without being intimately
acquainted with the existing literature which would undermine the integrity of
the grounded theory process.

Urquhart argues that the view of grounded theory which requires researchers
to be naive of the literature is a 'corruption of the idea of theoretical
sensitivity' and is both unhelpful and inaccurate (2001: 18). In order to
present a proposal for ethical approval or research funding, the researcher
must demonstrate a working knowledge of the territory, including a familiarity
with aspects of the literature and key debates. However grounded theory
requires an open-mindedness on the part of the investigator and an ability to
set aside predetermined views; this is considered as fundamental to the
theoretical sensitivity of grounded theory . As Glaser asserted in the early
days of grounded theory, the theoretical rigor is enhanced by the researcher
'being steeped in the literature and associated general ideas' (Glaser, 1978)
and not coming to the study ignorant of dominant ideas.

Indeed it is not possible to produce a topic guide without a familiarity of the
main areas and themes of the situation of inquiry; whilst also acknowledging
that as the data collection gathers material, the topic guide may need
amending in order to take into account the emerging ideas.

The topic guide, in its first form, reflected the literature available up to 2008
which was dominated by child and adolescent academic psychiatry. This
inevitably examined the interaction between the GP and the patient, as
perceived from the 'outside position' of psychiatrist and there was a lesser

contribution from academic GPs who, because of their professional position would view the clinical interaction differently. The literature at the time reflects a limited appreciation of the multi-perspectivity of this area of inquiry and rarely appeared to take contextual factors into account. In keeping with this epistemological stance, the methodology underpinning the body of research available was also predominantly quantitative.

A review of the dominant themes emerging from the largely descriptive literature available up to 2008 suggested five initial key topic areas:

> The experience of consulting with young people regardless of the presenting complaint and how this differed from consulting with older patients
> The experience of consulting with young people who may have psychological problems associated with emotional distress
> Responding to possible 'mental health problems' presenting in young people
> Exploring the notion of depression and anxiety (as common mental health presentations) in young people
> Soliciting views on the role of GPs in promoting emotional well-being

These five areas were present in the topic guide from the earliest interviews. They became modified as the early analysis demonstrated new areas of discussion which needed to be explored in subsequent interviews. As the analytical tools of situational analysis were increasingly employed, the guide was modified to take the early findings into account.

Later additions to the topic guide included asking GPs to consider the impact of structural changes associated with the delivery of general practice in the 21st century and an inquiry into how the changes might have impacted on their individual approach to offering care; underpinned by their own priorities and values.

The topic guides can to be found in Appendix B.

Theoretical sampling

The methods of the study employed theoretical sampling to determine who would participate in the study. Theoretical sampling is central to grounded theory and its progeny, the 'theory-methods package', known as *situational analysis*. It is the process by which the researcher inductively develops an emerging idea of the theory based on the data generated; and seeks to substantiate or over-throw the emerging theory in the light of the subsequent collection of further data. Theoretical sampling provides direction in the pursuit of empirical materials and guides further recruitment of participants.

A formal definition by Corbin & Strauss asserts:

> *Theoretical sampling is a method of data collection based on concepts/themes derived from data; the purpose of which is to collect data from places, people, and events that will maximize opportunities to develop concepts in terms of their properties and dimensions, uncover variations, and identify relationships between concepts.* (2008:143)

As the authors above comment, it is often in the 'doing' that the notion of theoretical sampling is made real. In this study the participants were recruited on the basis of their likely contribution to the stage of analysis at the point at which they were invited to participate. To illustrate, the first four participants were selected on the basis that they were all experienced GPs, established in practice for a mean duration of twenty years or more, and in one form or another had a particular specialist interest which would contribute to staking out the wider borders of the situation of inquiry. By choosing participants who would have had sufficient contact with young people over a sustained period of time in clinical practice, theoretical sensitivity would be enhanced, rather than by selecting at random a small number of GPs whose length of service and thus clinical contact with young people could not be assured. GPs with an additional role could also be assumed to have reflected on how contemporary general practice was delivered and how their particular interest could be accommodated, or not, in the current landscape of general practice.

The first four participants were all known to the researcher and approached directly. Once contacted, if the respondents expressed interest in the study then the study information sheet and consent form, as presented to the ethics committee, were sent out either electronically or by post and a reply awaited. All four agreed to participate. Two were interviewed at home, one in their surgery and one at a PCT base. Each interview lasted between 60-90 minutes. With a participant's permission each interview was audio-recorded with consent, using a discrete digital recorder, and transcribed verbatim by a professional transcriber. This element of the study had been funded by a research grant from the RCGP Scientific Foundation Board, awarded in 2008.

The particular specialist interests represented by the first four participants included having worked in CAMHS; or working with patient populations with substance abuse problems; or having a lead role in a PCO for mental health. All four worked in areas of predominantly high socio-economic deprivation although one practice had a university student cohort who represented a more affluent section of society.

The first four interviews were conducted within four weeks of each other and each interview was analysed within seven to ten days of the encounter, using both the transcript and the audio-recording. This immersion into the raw data allowed for ideas from each interview to be considered and woven into subsequent interviews whilst still fresh; at the same time following the topic guide as the principal 'route map' for the interview.

Subsequent data collection would be guided depending on what concepts were generated by the analysis at this stage. For an exploratory study as exemplified by this study, the seminal value of using theoretical sampling is its ability to take researchers into uncharted waters and be driven by concepts rooted in the data. By enabling researchers to take advantage of the fortuitous turns inherent in inductive inquiry it allows new insights to be appreciated.

Under the section 'the analytical process' the further recruitment of GPs to the study is discussed.

Theoretical memos

Critical to grounded theory is the capturing of fresh insights into what might be emerging as new and potentially theoretically relevant so that the notes can be revisited once recorded. This is achieved by the writing of theoretical memos which are the written or diagrammatic recordings of the analysis. They have been defined by Glaser as

> *the theorizing write-up of ideas about codes and relationships as they strike the analyst while coding.* (1978)

Corbin and Strauss (2008: 117-129), writing more recently, are more creative in their discussion of theoretical memos and advocate a plurality of approach which encourages the investigator to make notes, jottings, sketches, diagrams whilst 'wading in the data'. Theoretical memos might be seen as a 'private diarising' (idem) with which the researcher engages, but they have a more compelling purpose in promoting active engagement with the data and the evolving concepts as they take shape. In writing memos the inter-connections between ideas often emerge.

A selection of memos are stored in Appendix C.

Field Notes

Another form of theoretical memos are the field notes which are the recording of spontaneous impressions made just after an interview, or encounter. The closer the notes are made to the time of the event the likelier they are to record the investigator's spontaneous responses. Having said that, Patton (Patton, 2002) suggests that there is *no* unfiltered observation and any appraisal of a situation unconsciously and automatically categorises the images and dialogue heard, in order to map to existing constructs (in the researcher's head).

A structured format for recording initial impressions was used in conducting this study. The areas which were addressed immediately after an interview were:

First impressions (what was most prominent?)

What was important to this participant?

What was new? Surprising? Unexpected?

Inhibitory factors (to the interview)

Facilitatory factors

What was my role in the *interview*? (How did I see my contribution?)

A selection of field note memos are included in Appendix C.

The Analytical Process

With the completion of four interviews, each informing the next, it was possible to see the landscape of the situation of inquiry being traced out.

> *Analysis is a process of generating, developing and verifying concepts –a process that builds over time and with the acquisition of data* (Corbin & Strauss, 2008: 57)

The first interviews produced the data which launches the early stages of analysis known as 'open coding' as described earlier. This requires a 'brainstorming approach to analysis' (Corbin & Strauss, 2008: 160) as the data is kept as flexible as possible to

> *open up the data to all potentials and possibilities contained within them.* (idem: 160)

Once the open codes have been articulated they can be further examined to yield the higher-level concepts which coalesce into more focused codes. Once distilled into focused codes the core themes emerge which become the axial codes: the principal axes about which all the data can be organized (see pages 62-3).

Using the tools of situational analysis allows the data to be examined from multiple perspectives and brings fresh insights as well as articulating the 'silent voices' and allows marginal positions to be included.

The analysis of the data occurs on a continuous basis and includes listening to the audio-recordings; applying mapping techniques; re-examining transcripts; writing memos and producing conceptual maps; all happening often concurrently. For the purpose of clarity the analytical stages will be presented below in a chronological fashion.

Open Coding: the early themes

Coding is seen as a means of making the data more manageable and provides a language for talking about the data. The open codes reveal the areas of spontaneous discussion which GPs raised during the interview indicating the areas which are of primary importance to the participants . This is where the researcher begins to see what is important in the situation of inquiry for its key actors.

Such insights, to be captured in theoretical memos and field notes, might be seen as the key to understanding the competing demands and tensions at play when GPs consult with psychologically troubled young people, but in their raw state, they lack theoretical rigor. It is through the iterative analytical stages of focused coding which lead to a greater understanding of these early themes and takes the researcher nearer towards determining the axial codes, as understood by the investigator.

Five areas, relating to problematic aspects of clinical practice, emerged from the early interviews and were to be explored in the subsequent interviews thus arriving at a more detailed set of open codes.

 They can be summarized as

1)   Anxiety on the part of the GP when faced with these consultations

2)   Patterns of communication issues and associated difficulties

3)   How young people present

4)   Availability of time for the consultation

5)   The external context, including what is available to help or hinder GPs in this area of clinical practice

In order to expand on these themes the next stage of the analysis was guided by the theoretical sampling of new participants which would allow these open themes to be further explored and 'thickened' (Geertz, 1973) to produce a full set of open codes. The open codes would then be examined using the tools of situational analysis.

The second tranche of participants to be interviewed were a much broader group of GPs. They were selected on the basis of their contribution to 'unpicking' these five broad themes. The next five GPs were recruited on the basis of demographic and clinical characteristics including gender, age, geographical location, clinical areas of interest, contact with young people and experience of accessing secondary care and other services.

An early finding pivoted around the idea that female GPs might be more at ease communicating with young people experiencing emotional distress in the consultation. To explore this idea the next three participants were male GPs who worked across different geographical terrain and served practices with contrasting socio-economic profiles. One GP worked in a practice which included both high-earning patients and patients living on low incomes and as such was less typical as most other participants tended to be based in practices which were more homogenous. The contrast here offered the GP more opportunity to reflect on how the socio-economic profile of young people might interact with presentations of emotional distress when compared with practices with little variability and hence where the patient demographic details became seen as the 'norm'.

Other ideas which had emerged from the early interviews were that younger GPs might have fewer difficulties communicating with young people, and that a constellation of younger age and female gender might reduce anxiety in consultations concerning young people and emotional distress.

Subsequent theoretical sampling addressed these ideas and continued to explore the key themes. The GPs recruited in the next tranche were a mix of ages, an approximately even spread across male and female and working in different settings.

A number had additional roles, again chosen for their contribution to the area of inquiry such as one GP working in a practice which had a once a week 'teen drop-in clinic' offering contraceptive and sexual health advice for students from a local senior school during term-time, over the lunchtime break. Others offered experience of working in local contraceptive and sexual health services (CASH) and child protection.

Additional characteristics which were addressed in the theoretical sampling included the possible impact of an interest in education and training and whether this might equip a GP to respond more effectively to dealing with emotional distress; and the employment status of a GP (whether salaried or a partner). During the preparation of the topic guide the researcher had attended a research meeting led by child psychiatrists which had suggested that young people might be more comfortable consulting with GPs with whom there was a certain anonymity, based on early fieldwork. Given that this study was exploratory and the terrain relatively under explored, it seemed appropriate to investigate this idea as part of the whole exploration, in order to see whether any robust data was generated to support or refute this notion.

The Open Codes

Whilst recruitment and interviewing were occurring; the next stage of analysis involved producing a 'working list' of all the codes found in the initial reading of the transcripts which could be added to as interviews progressed. The codes both 'explode' the data contained within the interviews and at the same time allow it to be reduced into manageable chunks which allow for ease of navigation and facilitate deeper analysis.

This was achieved by drawing situational maps, both the ordered and messy kind, (see page 72) with the open codes inserted into the maps to stake out the territory and begin to articulate the key problematic areas for GPs. As the iterative process continued, threads appeared between the themes which were either strengthened or abandoned according to the outcomes of applying the tools of situational analysis.

The full list of open codes and the situational and social world arena maps are located in Appendices D and E.

Theoretical sampling continues

The next tranche of GPs to be interviewed would need to be selected on the basis of what they could contribute to determining the key elements of the higher level concepts and how they might influence each other. Exploring the external constraints upon a GP's practice would prove to be a significant component of this stage of the analysis as it had begun to be discussed as a naturally occurring topic; having not been formally included in the topic guide for the initial set of interviews. This is largely because the extant literature was mostly generated by psychiatrists whose understanding of the dynamic context in which general practice is delivered is inevitably superficial; as would be a GP's understanding of the historic-political detail of the CAMHS context.

It was now necessary to explore the experience of GPs at the intersection of primary and secondary care and to look at their observations and reflections of referring young people to CAMHS or alternative provision. Moreover the emerging data called for an examination of the influences outside of the consulting room and how they bore down upon decisions GPs made regarding their degree of engagement with young people.

Consultation style was emerging as a theme and the analysis sought to look at the influences upon a GPs' consulting style. For example by considering what was the role of medical education and the acculturation into medicine , largely mediated through experiences of undergraduate education; including both the formal and 'hidden' curriculum. This would include looking at what role external constraints play in promoting or prohibiting particular decisions and actions in the clinical encounter. In addition the analytical process began to examine expectations upon GPs to respond to emotional distress in young people.

In order to drill down into the relationship between primary and secondary care, a couple of GPs with specialist interest in mental health were recruited. As GP understanding of mental health and illness was interrogated,

examining the role of epistemological frameworks emerged as being significant; for without an acknowledgment of how a GP used epistemological frames of reference it was difficult to interpret a GP's understanding of young people's emotional distress.

Further theoretical sampling included the recruitment of a GP who was a specialist practitioner in managing substance abuse in young adults and a CBT practitioner; a GP who worked in a university town and saw a regular number of young adults with severe and often new presentations of serious mental illness and a number of GPs at different stages in their careers, of different employment status and representing a range of practices of contrasting socio-economic settings.

The sample also sought to include GPs who might express a range of views because of their more diverse professional experience, for example through working with 'challenging patients' such as those with a history of substance abuse, or violence, or who currently worked with patients who demanded a higher skill in managing the clinical encounter. For example, one GP worked with violent patients who had been removed from other GP lists and were subsequently allocated to his practice list by the local PCT. GPs whose practice was more generic, that is to say more 'mainstream', and who might hold different views to those GPs who choose to work in more demanding clinical environments were also actively recruited to interrogate the full range of GP experiences.

The sample of GPs recruited by the tenets of theoretical sampling was concluded with two female GPs in their late 40s to early 50s. Having thoroughly explored the analytical concept of age and gender as possibly pivotal in determining a GP's degree of engagement this concept was rejected as theoretically empty.

Below is a table to represent the characteristics of the theoretical sample.

Table of GP Participant Sample

Participant Number	Gender	Age	Salaried or Partners	Practice location and dominant socio-economic profile of patient population	Additional professional experience
1	Female	50-59	S	Semi-rural Deprived	GP Postgraduate education
2	Male	50-59	S	Urban Deprived	Experience of working with substance misuse in primary care
3	Female	50-59	P	Urban Mixed : largely deprived; pockets of wealthy students	Experience working as Clinical Specialist in CAMHS
4	Female	40-49	S	Semi-rural Deprived	Mental health Lead for a PCT Interest in chronic fatigue syndrome
5	Female	20-29	S	Urban Deprived	
6	Male	40-49	P	Semi-rural Mixed: largely affluent	
7	Male	40-49	P	Semi-rural Mixed : broad distribution of income amongst patients	Child Protection Lead for a PCT
8	Female	30-39	S	Semi-rural Mixed : broad distribution of income amongst patients	

9	Male	50-59	P	Semi-rural Mixed : broad distribution of income amongst patients	GP lead for 'teen drop-in' clinic
10	Male	40-49	P	Urban Deprived	Mental Health and Child Protection Lead for a PCT
11	Female	20-29	S	Urban Deprived	
12	Male	30-39	S	Semi-rural Mixed: largely affluent	
13	Female	30-39	S	Urban Deprived	
14	Male	40-49	P	Urban Deprived	
15	Male	40-49	P	Semi-rural Mixed : broad distribution of income amongst patients	
16	Female	20-29	S	Urban Deprived	
17	Male	30-39	S	Urban Deprived	
18	Female	40-49	P	Semi-rural Affluent	
19	Female	50-59	P	Semi-rural Mixed : broad distribution of income amongst patients	

Analysis continues: Defining the territory from the GPs perspectives

Using analytical constructs

With the interviews completed and the open coding (and more focused coding stage accomplished), the analysis was now at the stage of interrogating the situation of inquiry in order to look at the underlying processes. For example, what might be the direction and the magnitude of influence of individual codes and how could the codes be drawn together in order to arrive at the pillars of a possible conceptual framework?

Grounded theory involves both breadth, as in scoping the field and also depth of inquiry. It requires the researcher to be agile and to be able to alter their lens from the close-up examination to the panoramic view. The data analysis began with scoping the situation of inquiry and determined five problematic areas for GPs. The data gathering then attempted to burrow down and gather empirical materials which would offer data to shed light on why these areas were problematic for GPs.

The areas which presented as challenging for GPs from the outset are presented again below:

1) Anxiety on the part of the GP when faced with these consultations

2) Patterns of communication issues and associated difficulties

3) How young people present

4) Availability of time for the consultation

5) The external context, including what is available to help or hinder GPs in this area of clinical practice

By the time the open coding had been completed, supported by the application of Clarke's cartographic tools, the problem areas, had collapsed into

1) Anxiety on the part of the GP when faced with these consultations

2) Patterns of communication issues and associated difficulties

3) How young people present

4) The external context

5) Different approaches to practising medicine

These domains map to the situational analysis diagrams (see Appendix E). The notion of time as a key area of concern was subsumed into 'patterns of communication' and also 'the different approaches to practicing medicine' which were seen in the data.

Each of these areas will be discussed in turn below. A detailed explanation of each of the domains will contextualize the listed open codes for the reader (see Appendix D) and illuminate how the axial codes, to be presented in the following chapter, were derived.

A key analytical construct was developed at this stage of the analysis. This was the concept of engagement and arose out of a discussion held amongst members of the University postgraduate theoretical discussion group. 'Engagement' offered itself as a useful theoretical device for exploring why GPs behaved differently towards young people with emotional distress. Using this construct the GPs' behaviour could be examined in relation to whether they were able to navigate the tensions within the consultation and work with the young person or not.

The construct of engagement thus informed the application of the tools of situational analysis and is incorporated into the discussion of the domains below.

This section of the chapter will take each of the problematic areas in turn and is illustrated with verbatim quotations taken from the interview transcripts. Each quotation is followed by four identifiers, in brackets, which give the following information: GP participant number; gender; age band; salaried or partnership status.

i.   Anxiety on the part of the GP

Anxiety experienced by GPs when faced with an adolescent in emotional distress, was one of the most powerful early findings. Anxiety underpinned all the problem areas. GPs felt anxious about how young people consulted, and

what they were presenting with when it became apparent that this was not a

> *straightforward consultation regarding acne, contraception, or minor*
> *illness.* (02; M; 50-59;S)

The GPs spoke of the variety the presentations might take including 'not getting on with parents', irritability of mood, under achievement with poor attendance at school and coming into contact with the police.

> *They are missing school, they are in trouble with the police, youth*
> *offending team or not uncommonly the parent just comes by*
> *themselves....I never get a 14 year old who is acting out saying*
> *you know I'm in trouble with me mam and dad.* (10; M; 40-49;P)

Furthermore, the lack of external services to which patients could be referred and the intellectual and professional conflicts which arose when certain approaches to medicine were applied in this clinical arena all exacerbated professional anxiety.

The invisibility of young people's distress is also anxiety provoking:

> *It's always a worry isn't it that you just completely get it wrong. I*
> *mean I am conscious of this, I had someone on Monday, parents*
> *into my surgery whose son had just hung himself at 21. I'd never*
> *seen him, he was a patient and they had no idea anything was*
> *wrong, nobody did; so you've always, there is always that*
> *underlying thing isn't there about you might miss something*
> *catastrophic.* (01; F; 50-59;S)

The participants referred *en masse* to the lack of clarity around the topic. Some GPs were more cognizant of the largely psychosocial nature of adolescent mental health, as illustrated below:

> *....these problems are like icebergs, there is so much that is not*
> *discussed, that is under the surface; and there is so much that*
> *can't actually be sent to anyone cos a lot of this is borderline:*
> *medical and non-medical. But you've got to go there - to see if it's*

*medical, and if it turns out not to be medical it can still be a
problem.* (06; M; 40-49;P)

The unpredictability of a young person's actions also fuelled GP anxiety
because of the known association with attempted (and completed) suicide,
which many of the GPs spoke of, as articulated below:

*Uncertainty is very key to this group when you're looking - in terms
of depression and suicide risk and things like that, you know, it's
standard. Young people particularly young males are quite at risk
of just going off and doing something. (*04; F; 40-49;S*)*

The anxiety which triggered uncertainty about clinical decision making
summarized as

...the main anxiety is what to do. (07; M; 40-49;P)

was unpicked using the open codes. These include the lack of clarity around
what the presenting problem is; the difficulty associated with exploring
contextual factors such as family structure and family dynamics, cultural and
social mores; the negative correlation between the relative infrequency of
presentations with the high risk associated with adolescent depression and
suicide and the emotional intensity which often characterises these
exchanges, so often presented as 'crises' requiring urgent action.

Yet, certain GPs were able to handle the anxiety provoked by these factors
and others were not. The maps of *situational analysis* looked at what might
contribute to this. An early idea looked at the degree of experience of GPs.
Given the breadth of the sample, which included GPs with five years in
general practice to GPs with 25 years, the vignettes they shared and the
observations they made, did not support a simple analysis of experience
resulting in greater confidence. Indeed some older GPs felt less confident as
they were more aware of the vagaries and complexities of life whilst younger
GPs appeared emboldened by their pragmatic approach and easy familiarity
with younger patients.

Applying the concept of engagement proved more theoretically useful and led to the construction of a series of *positional maps* (see Appendix E). This allowed for theoretical probing of the data and explored different positions taken by GPs in the data and also articulates silent or silenced positions which Clarke suggests should trigger further data collection or be noted in theoretical memos (Clarke, 2005:136).

ii. Patterns of Communication and associated difficulties

There was a clear consensus that communicating with young people was often problematic

> *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 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)*

For some GPs the difficulty was attributed to the young people themselves because "they don't communicate":

> *I think this is maybe where our Achilles heel is that we are probably not good at picking up the emotional psychology because they don't communicate, you know, and because they are a difficult group. You know, you're sort of feeling it, 'I will be glad when they walk out the door'. (15; M; 40-49;P)*

Open codes generated here included problems associated with talking across generations; gender differences (both of patients and GPs); adolescence being associated with taciturnity and a reluctance to talk with older, authority figures; and verbal and emotional literacy (again, both of patients and GPs). Female patients were viewed as being easier to talk to. Those GPs who gave examples of engaging well with younger patients

talked about the importance of developing rapport through verbal and non-verbal language and of this being of particular importance when communicating with this age group of patients

> ....*I'm, usually with my foot on the computer modum, leaning back most of the time, not imposing, I know it's old sort of Royal College stuff - not having the desk in the way and you know, I think I get on alright with them (adolescents).* (14; M; 40-49;P)

In general it was discussed that younger female patients were easier to engage than young men, although it was suggested that this could be moderated by a GP's own personal experiences.

> *I think, girls are like easier, cos generally they tend to be more chatty ......I think with boys as well, it's sometimes quite difficult for them to talk to an older woman, ...(but)I don't know, I don't think it's any easier with an older male GP. (*01; F; 50-59;S)

Patterns of communication become conflated with consultation style in the analysis and exploring how some GPs were able to connect more easily with their younger patients appeared to hinge upon adopting a more naturalistic idiom and vernacular speech in contrast to either trying to adopt adolescent parlance or 'lingo' as it is termed below; or alternatively a more technical form of language which will often alienate younger patients because it is so unfamiliar. These findings are expressed in the quotations presented below

> *I struggle to work out how to word sort of mental health questions with to the sort of under 16 year olds particularly... using those sort of questions with young people often draws a blank face, and, so it's something I have to rephrase I suppose. I feel that I don't necessarily know their kind of lingo if you like, on mental health issues so much.* (17; M; 30-39;S)

> *I find it quite easy to actually communicate and talk to younger people. I don't know if that's maybes being a younger person from the same area I can identify with some of the issues that are*

> *coming up.... keeping it sort of very basic and in their language I think always works quite well. (*13; F; 30-39;S*)*

Using a more flexible, open ended approach to dialogue was generally found to have a positive effect at putting young people at their ease.

A key pattern of communication seen in consultations with young people is the *triadic consult*. This refers to an adolescent being seen in the presence of 'another', more commonly a parent, or relative, or it might include a friend. This challenging mode of consultation was mentioned by every participating GP. For almost all, this scenario, although familiar, was rarely comfortable and often presented a GP with a sense of conflicting priorities and agendas.

> *They come with a parent so it's always difficult; you've got three people in your consultation. Two people to mirror the body language and different agenda's so it's just inherently difficult I think. The parent's always got a very fixed agenda, the child more often than not at that age is not very forthcoming, and sometimes it's difficult to tease out what important to them.* (12; M; 30-39;S)

Given the breadth of the sample the data revealed a range of positions GPs took regarding how they conducted the triadic consultation and managed the multiple agendas. These included never asking the parents to leave (such as the young male GP above who felt it was inappropriate for him to ask 'a senior' to leave), to GPs who always insisted on seeing the young person alone; from viewing parents as obstacles to creating a good rapport with the teenager to accepting that one needed to work with the family 'for better or worse'; from recognizing that certain presentations benefitted from additional collateral information from family members such as when a young person displays a disordered eating pattern; to wanting to encourage the young person to consult independently.

Contrasting consultation styles, ranges of experience and views on why young people consult allowed the data to be interrogated in a meaningful manner and offered early insights as to why some GPs were better able to

negotiate the complexities of the triadic consult and engage more constructively.

These insights, which were developed by writing theoretical memos, drawing diagrams and undertaking mapping exercises would lead to the building of the axial codes.

iii. How young people present

A dominant early finding was the heterogeneity of young people and the importance of keeping an open mind, as indicated below

> *I think it all depends again on the person you've got in front of you and the style that you're using, I don't think there is no such thing as 'the typical teenage presentation'.* (13; F; 30-39;S)

The variability of adolescent presentations was a cause of concern from GPs who felt anxious about the unpredictability of the presenting story and where it might end. However, those GPs who were prepared to accept that adolescent development was neither linear nor uniform drew upon a range of consulting styles to connect with young people and took the young person's emotional state and demeanour as their starting point. GPs who were more positive about working with teenage patients were keen not to pressurize young people into talking when they seemed reluctant.

> *I think trying to force someone into talking through matters, and we can't make somebody open up to us, and I feel quite sure that if I tried I wouldn't succeed and also I would well and truly shut the door for that person to come back. (*18; F; 40-49;P)

Gender differences also exert an influence. As referred to earlier, young women on the whole, were found to be easier to communicate with. However there are also differences in health seeking behaviour between young men and women which demand a greater degree of awareness on the part of the GP as suggested below:

> *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, so when males present .. I often think wow, this could really go off in a big way.(*14; M; 40-49;P)

Although most young people were viewed as a predominantly healthy population their complaints in primary care tended to be of a well-contained nature, typically respiratory, dermatological or musculo-skeletal in nature and described by a majority as 'straightforward':

*They're a refreshing change....they don't usually bring multiple problems. (*03; F; 50-59;P)

However, once emotional distress is a possibility as 'a differential diagnosis' then identifying what is happening becomes much more challenging:

There are those issues of trying to calibrate and diagnose young people ('s mental health problems).. I don't have the out and out objective tests.....it doesn't feel like it easily fits within any ticky box guidelines ....The commonest situations that young people will come to me with is the land of unhappiness borderline depression, not coping with some changes that are going on with their life whether it's relationship, school, work. (06; M; 40-49;P)

The finding that it is young people's (problematic) behaviour rather than their mood which indicates an emotional health problem demonstrates something of the task GPs are faced with if they wish to address psychological distress

..it's more misbehaviour at school, truancy, you know problems with family dynamics, difficulties with parents that sort of thing. You don't really see much in the way of depression in that age up to 16, 17. (12; M; 30-39;S)

iv. The external context

Developing a greater understanding of the external forces operating upon the consulting room required a more conscious probing in interviews undertaken with the latter half of participants recruited for interview. This grew out of a growing awareness that there were external factors shaping the decisions GPs made, and the responses they enacted, towards their patients which often had their origins outside of the clinical encounter. How conscious participants were to these tacit influences varied and it was not always possible for GPs to articulate the power of these shaping influences. The influence of external factors was made manifest through undertaking situational mapping exercises; by probing the data and asking more focused questions.

The term 'structural factors' is taken to refer to those conditions which lie outside the agency of individual practitioners but which nevertheless directly impact on their practice. Structural factors can be viewed from the perspective of where they most exert their influence: at practitioner; practice; regional (local primary care organization); and national level.

At practitioner level

All of the participants regardless of age or the university institution they had attended were unanimous in their consensus at having received no education regarding adolescent mental health in their undergraduate curriculum. How this later impacted on their confidence and competence is reflected upon by a GP below

> *I mean when I trained you certainly didn't get any that I can remember, any sort of specific training in it, and I don't know what the situation is now particularly, it was very much learn as you go really. So I think it probably would be useful to have more sort of background training really. ...and I think, yeah, as a GP, it would help probably, to make a diagnosis earlier and to help to manage it really effectively because we probably can do more in general practice than we are actually doing in the management side I suspect. (*19; F; 50-59;P)

At practice level

Three issues emerged which the sample of GPs felt impacted upon consulting patterns with emotionally distressed young people.

The first was 'continuity of care' which the majority felt had been disrupted by recent incentivized systems which reward practices for providing improved access within 24 hours. Where building a relationship of trust was important structural factors which prohibited a GP from providing continuity of care would adversely affect therapeutic relationships with troubled young people in primary care.

> *We don't have continuity anyway in this practice with people because of this same day access thing. They see who ever is available. (*07; M; 40-50;P)

Secondly, the QOF was seen to have had little impact upon consultations with young people, given that there were few QOF points allocated to this age group apart from gathering data pertaining to smoking and monitoring of asthma. However, broader, philosophical issues were identified which tapped into the underlying motives behind GP's offering care to patients (of all ages), both in terms of promoting good health and in health care delivery.

The participating GPs expressed a diversity of opinion about the impact of QOF with one perspective presented below:

> *If we are talking a general target and QOF society, I despise it. I think it's destroying everything that is central to the GP patient relationship, you know patients come in and you're saying, well shall we check this, do that, and you've put up a little picket fence in between you and the patient before they've had the opportunity to actually say "well actually I am really worried about this doctor; thank you very much for spending 12 minutes making sure that you are going to get paid". (*14; M; 40-49;P)

A contrasting view was offered

.....it's not a quality outcome framework- it's a points orientated system which I've got to say is better than nothing, you know if you asked me has QOF helped the health of the nation then yes it has. It's made people aware of the importance of statins or lowering cholesterol. (15; M; 40-49;P)

The iterative analysis suggested that the GPs viewed their function and purpose differently. Exploring how and ultimately why GPs adopt different approaches began to shed light on the notion of engagement or resistance to engaging with adolescent patients and would be a useful theoretical device contributing to the subsequent development of the axial codes

Finally, the third identified issue was consultation length. In the main the GPs did not cite pressure on time as being a major discentive to engagement with young people with mental health difficulties, although time as a constraint was mentioned in most interviews. The GPs in the study adopted a variety of positions with regarding to operating within ten minute consultations. One expressed view was the idea of GPs having 'multiple ten minute slots' over time. Another view was the notion that consultation time had a certain elasticity and should be given according to need, with a young person disclosing emotional distress as one high on such a priority list

*I think mainly because the way I see it is that if they need 20 minutes they need 20 minutes and if you spend 10 minutes with somebody that needed 20 minutes you might as well not have bothered. So I will do it, but I think with young people that's even more important. I think, I just have this fear with young people that if one person fails to listen that could be the end of it all and so if they need 30 minutes then that's absolutely fine. (*08; F; 30-39;S).

Also operating at practice level, an external factor has been the changing career structures of GPs. The potential impact of the employment status of a GP has been referred to earlier and was one of the characteristics to be taken into account during the theoretical sampling of participants.

The most consistent finding here was that GP partners were more likely to be committed to both their practice population and the wider community and much less likely to be 'in professional transit'. Their local knowledge of the social context was likely to improve their interactions with young people, that is where the GP was prepared to and able to engage. This is not to say that a salaried doctor could not achieve the same level of social knowledge but the longevity that comes with partnership certainly facilitates this process. The notion that young people might seek out salaried or locum doctors in preference to established partners was not borne out and the data suggests that this would be a reductionist and overly simplistic explanation of help seeking behaviour by young people experiencing emotional distress.

At regional level

Structural influences operating at the level of a primary care organization or at a regional level mostly centred upon the relationship between primary care and the provision of secondary CAMHS services. The data showed geographical variations in the degree of responsiveness shown by CAMHS teams towards their GP colleagues. Below is a selection of quotations which indicate the range of responses. The first two capture the frustration many GPs working in at least four CAMHS catchment areas (as represented by the sample) expressed:

> *I suppose the only worry, the only concern I have, I don't mind really 'opening up boxes' but I'm conscious that there are rubbish services out there to pick up when people do have a problem. (*01; F; 50-59;S)

> *I struggle with CAMHS . They don't seem to accept my referrals, whether it's just me or not, they want some more details or then they say they never received it in the first place, and then they reject the referral. (*02; M; 50-59;S)

The two extracts presented below indicate a more positive relationship from GPs working in two different geographical regions:

We have a good relationship with CAMHS...just thinking they did do quite a good educational morning with regards to referrals and what they can offer and options and things. (16; F; 30-40;S)

In the adolescent group I've actually found them quite helpful which differs dramatically from the adult service. ..I think perhaps because there is the heightened sense of alarm and awareness in the younger age group....and I find the CAMHS are actually very good. (14; M; 40-49;P)

At national level

Finally, with regard to external influences operating at a national level the GPs in the sample spoke of policy and fiscal structures from a number of different perspectives. Some GPs preferred to follow external direction in general in their practice. Hence where there are no agreed protocols or NICE guidelines they are less likely to directly intervene; as shown below:

...Yeah the more often it's short term distress, you know some depression sort of symptom. NICE guidelines a few years looked at depression in young people & kind of hampered our ability to do anything with them really. (07; M; 40-49;P)

Others who were more engaged suggested that GPs might offer more to young people but the lack of clarity about what GPs are expected to do in terms of supporting young people with early mental health difficulties made this difficult. Numerous policies have emphasized the role GPs might play but no participating GPs referred to these documents or seemed aware of them. For a small number there was a sense that GPs could be more actively involved but it would need leadership and improved support from secondary care services to change the status quo.

v. Different approaches to practising medicine

The theoretical sample allowed for a diversity of approaches to practising medicine to be revealed. These were to range from a strictly procedural approach to a more intuitive and relationship based approach where the GP inclined towards taking the lead from the patient, where possible. The

spontaneous use of vignettes proved a welcome addition to the topic guide and was often a proxy indicator for a GP who was used to regularly interacting with young people. Using the construct of 'engagement – disengagement' it was possible to begin mapping styles of consultation with a preferred approach to practicing medicine, or the *modus operandi.* Those GPs who tended to be less engaging often seemed to prefer a more formulaic style and leaned towards a more rigid pro forma than their counterparts who were practising at the other end of the spectrum.

The more engaging GPs seemed to be more flexible and accommodating and were ready to follow where the consultation was taking them

> *I like to sense the way a consultation is going; every now and then I have to drive the consultation you know, when you've got time restraints and things like that, but I do like sensing the way it's happening; so I suppose an empathetic style, you know, trying to recognise their needs rather than trying to impose my demands.*(14; M; 40-49;P)

Those GPs who in general favoured a structured consultation were keen on the idea of a screening tool to be used in consultations with young people:

> *......I think some structure would be quite helpful; you know I'm conscious of the fact that young people do operate differently from adults and there are a whole different set of issues which are relevant; so having some sort of structure to do it by would be useful I think, don't know what format it would take, but. (*07; M; 40-49;P)

At this stage it was not yet evident what where the drivers shaping the preferred *modus operandi* and the degree of engagement, although it was clear that it was not explained by the age or gender of the GP.

The use of analytical mapping tools would help to determine why certain GPs adopted a more mechanistic approach to their consultations with young people and others took a more spontaneous position in which they aimed to

develop a relationship before arriving at a definition of the 'presenting problem'.

An early dominant idea with explanatory potential was the concept of power, as exerted or shared by the GP, in a consultation with a young person. The idea that a GP's ability to be flexible with the power they potentially wield in the clinical setting was interrogated using positional maps. As the mapping exercise revealed, GPs who 'held onto' professional power were more likely to be anxious in this clinical arena than those who could admit to professional uncertainty (see Appendix E8). However, the use of power as a single theoretical lens lacked sufficient explanatory weight. It could not account for all of the data gathered which was further examined to arrive at the three axial codes; presented in the following chapter.

Reaching theoretical saturation

The interviews were concluded over a period of 18 months. Although they had successively informed each other they were to be read iteratively and examined many times over the period of the analysis. Each re-reading would often yield new data depending on the perspective taken.

The decision to cease recruitment is normally said to have occurred when no new insights are forthcoming and the interviews appear to be reaching a point of repetition. This stage in grounded theory is known as '*saturation'* which is summarized by Charmaz as

> *categories are saturated when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories.* (Charmaz, 2006: 113).

This assumes an almost linear quality to data gathering and analysis which, as the methodology and methods section of this thesis have outlined, is much more circuitous than it is linear. Charmaz herself is critical of an uncontested notion of saturation and introduces the idea by Dey of *theoretical sufficiency* (1999: 257; cited in Charmaz, 2006: 114). This concept speaks of categories which are *suggested* by data, rather than

confirmed, and thus is more in keeping with the best fit approach of grounded theory conducted in the real world, as presented by this thesis.

It was certainly the experience of this researcher that the data offered multiple possibilities of interpretation, depending on the lens that was being applied and the analytical devices being used at the time. For example, was 'experience' the lens, or 'personal and professional contact with young people' or 'age', 'exposure to adolescent psychiatry', 'style of consulting', or 'approach to practice'? So, each time the data was examined through a different theoretical construct it would yield new information. In this way the notion of 'saturation' being 'reached' was not representative of the analysis but rather the notion of 'theoretical sufficiency' seemed to be much more representative of what was actually happening.

Concluding observations on theoretical sample

Nineteen GPs participated in the interviews. Many more contributed in the wider discussions which have informed the use of the tools of situational analysis, offering a richer contextual scaffolding for the empirical data. As has been explained earlier, the GPs were recruited following the tenets of theoretical sampling. Participating GPs also completed a short, anonymous 'interviewee demographic data' form which may be found in Appendix A. All the participants were UK born and trained.

Three GPs who were approached declined to participate and one failed to respond. Two who declined gave their reasons. One was a senior partner with a specialist interest in 'dual diagnoses' in adult patients and felt that as a result of this specialist practice he saw far fewer younger patients and suggested one of the younger salaried GPs in his practice be invited. The second GP was about to get married in the near future and commence extended leave and felt unable to commit to a 60 minute interview.

Chapter Four: A Framework for understanding GPs' responses to emotional distress in young people

Introduction

This chapter will present the findings of the study building on the early stages of analysis presented in Chapter Three. The open coding stage of the analysis resulted in scoping out the analytical territory to arrive at a richer understanding of the situation of inquiry from the perspective of GPs. Five problematic areas were described which grouped all the open codes describing the analytical territory in all its complexity.

The next stage involves the development of the axial codes which are to be presented in this chapter. The axial codes give coherence to the analysis by organizing the data into its core categories. They can be viewed as 'the pillars' of the theoretical framework which is encapsulated by the selective code; to be presented in the following chapter.

Defining the pillars of the theoretical framework

> *The purposes of axial coding are to sort, synthesize, and organize large amounts of the data and reassemble them in new ways after open coding* (Creswell, 1998)

The grouping of the 100 (plus) open codes into five problem areas allowed greater manipulation and interrogation of the data using the constant comparative methods and the cartographic approach of *situational analysis*. Applying the device of 'engagement-disengagement' was a useful technique for exploring the different approaches adopted by the GPs and led to an analytical process of locating the GPs onto a spectrum of level of engagement. The maps of *situational analysis* were then applied to this conceptual model in order to establish the underlying mechanisms which promoted or restricted levels of engagement with young people in emotional distress.

The analysis demonstrated three domains which appeared to shape practice and which guided a GP's level of involvement in managing adolescent emotional distress. These domains were concerned with how the GP

negotiated the particular demands of the clinical encounter; how a GP perceived young people as a social group and the GP's understanding of their health needs; plus the knowledge frameworks which GPs drew upon. Where a GP stood in relation to these three domains would determine their degree of engagement with young people presenting with emotional distress

These three domains were then mapped onto the open codes to demonstrate the origin of the three proposed axial codes as being ground in the data. The domains refer to the three axial codes which are defined as GPs'

> Performance in the clinical encounter
>
> Perspectives on young people and their health needs
>
> Epistemological frames of reference

Each of these will be dealt with in turn below and introduced with reference to the original open codes which support the axial codes' development.

Performance in the clinical encounter

Clinical consultations involving young people presenting with emotional distress present a number of challenges for GPs. They often involve a third party, there can be a considerable degree of tension, anxiety and uncertainty for any or all of the parties concerned and the script of the consultation is usually unknown. This can result in the consultation often containing unpredictable and unexpected elements which might result in 'cultural clashes'. The latter refers to the role of the cultural context in the medical encounter and the opportunity for misunderstanding where two or more cultural expectations collide.

These three defining elements of the clinical encounter were then mapped to the open codes, the result of which is presented below.

**Open codes contributing to 'GPs' Performance
in the clinical encounter'**

The Triadic Consult	Dealing with the unexpected	Cultural clashes
Anxiety provoking	Anxiety provoking	Anxiety provoking
Unclear expectations	Unclear expectations	Unclear expectations
Competing agendas	Who can help?	Who can help?
Coping with uncertainty	Coping with uncertainty	Coping with uncertainty
Emotionally charged	All young people are different	Different social norms
Dealing with conflict	Young people themselves vary in their responses	Different codes of conduct
Associated with tension	Young people being embarrassed	Working out of comfort zones
Inadequate preparation	Inadequate preparation	Inadequate preparation
Risk /tendency to collude with parents	Risky behaviour	What are the boundaries?
	Unpredictability	
Who is in control?		Talking about drugs and alcohol
What are the provisions for accessing help?	What are the provisions for accessing help?	What are the provisions for accessing help?

Data from the study found a GP's performance in a clinical encounter which involved a young distressed person to be associated with a sense of anxiety, linked to uncertainty. The participating GPs described a picture of often not having a clearly defined working diagnoses in the first consultation; a sense of not knowing what to expect in terms of how the problem might unfold; nor of having a clear path of travel with definable and expected outcomes. This results in making the landscape of youth mental health daunting and anxiety provoking for doctors who are used to having practised routines for dealing with common presentations.

It never feels routine. (07; M; 40-49;P)

The encounters are described as '*sort of edgy and uncertain'.* (04; F; 40-50;S);

How a GP develops strategies for dealing with the anxiety and the challenge to both personal and professional integrity which can ensue, is pivotal to developing the theoretical model at the heart of this thesis.

The Triadic consultation

The triadic consultation refers to a patient presenting with a third party; in the case of young people this is usually a parent or guardian but it can also include a friend or chosen companion. GPs often spoke of young people experiencing problematic emotional distress as being brought to surgery under 'duress'.

> *...."Well this time I'm coming about his behaviour" and she*
> *dumped him down in the seat, as if he was exhibit A and said "you*
> *know, he never does what he is told and he never pays any*
> *attention and he's driving me mad and I think he's got ADHD".*
> (11; F; 20-29;S)

Where a young person has not voluntarily chosen or agreed to discuss their situation with a GP the challenge to engage the index patient is even greater. For those GPs who did not easily connect in these clinical encounters the tension from having unwilling actors in the consultation was difficult to surmount:

> *sometimes there is quite a lot of antagonism in the room.*
> *(*19; F; 50-59;P)

Given that the majority of young people experiencing psychological difficulties first meet their GP in a triadic setting, this has important implications for the relationship they may build with the GP. Where this has been consensual the young person is more likely to be ready to talk with the GP. Where they have been brought unwillingly, the GP's ability to engage the teenager is tested and only those GPs operating as 'high engagers' are

likely to succeed. As the theoretical model being proposed here will demonstrate, this will depend on a GP's position with regard to the interactions between the three axial codes.

As referred to in the previous chapter the participating GPs responded to the triadic situation in a variety of ways. The greatest clinical challenge was expressed as having the ability to differentiate between the needs of the young person and the needs of the parent, as expressed below:

> *I think I find it confusing to know what I am actually doing. I think often in that situation the parent wants to consult with me, with the youngster present and then the parents are interpreting for the young person what's going on, and so then you're deciding about what actually **is** going on..., I don't like the erm, sometimes I feel I am put in quite a difficult position by a parent, with them sort of wanting to collude with me, almost against the person who is actually sitting in the chair, erm, and so that can be a really tricky path.* (18; F; 40-49;P)

The 'collusion' which is referred to here was also a theme of other participants' transcripts and suggested that the historical practice of paternalism which marginalizes the young person's account places the GP and parent as potential ally and excludes the young person from the triadic arrangement. This is summarized below as

> *I don't know, because I've been in general practice for too long, but I do wonder whether it's still sort of perceived as GPs being , will always be, on their parents side in some ways...I don't know.... how they actually perceive you.* (19; F; 50-59;P).

Where the respective agendas of the parent and child are in conflict with each other during the consultation the tension is often palpable and places a responsibility on the part of the GP to manage this tension. One GP described this scenario as being akin to 'a boxing match' with the GP sitting at the ring side and often feeling called upon to adjudicate.

...the bit I sometimes find difficult is where the adults and young person are throwing emotions at each other and it's a little bit uncontrolled and part of me wants to step out and watch and part of me wants to step in and say something but if I step in whose side am I going to be on? (06; M; 40-49;P)

For a GP who is unsure of their responsibility and their ability to be effective, the resultant situation can challenge their sense of professional agency

...you tend to get the whole family in the room and it's all quite tense and everyone's quite erm, stressed basically. (17; M; 30-39;S)

This in turn results in the young person and their family losing confidence in the GP's ability to help and in turn is likely to lead to greater disengagement, often at a time when the young person (and their family) most need help.

However, for GPs who work well in these clinical situations, the role of 'arbiter' rather than adjudicator, can be seen in a more positive light; as is indicated below.

I think sometimes it's just being a third party, almost liaising with the parent and the child and sometimes I think it's possibly the first time they've actually opened up and said maybe their side, what they feel are the problems, when they've got a third party that isn't a family member or whatever, in the room. (19; F; 50-59;P)

The GP quoted here drew on her experience of community paediatrics and taking a lead role in children's health the practice. She was also a parent and had experience of parenting teenage stepchildren although she was hesitant of according this experience too much weight because of her interpretation of its "subjectivity".

This GP's account suggested an awareness of the power dynamics as being heightened in the triadic consult. This occurs at a number of levels. At a generational level there is the dynamic of the parent and the doctor having

more (symbolic) power invested in their 'authority' which can be intimidating for the young person, seen as 'the minor'.

At another level there can be 'a power struggle' between the GP and parent. Some GPs spoke of feeling powerless to challenge a parent who was forceful in their request for a referral to CAMHS

> ....the path of least resistance is just to agree. I had one like that recently but then actually the secondary mental health care professionals got back to me and said this isn't an appropriate referral and we had this whole conflict and difficulty and I had to write back to them and ...ask them for an opinion (12; M; 39;S)

Parents who appeared to have 'press-ganged' the young person into attending because of their own agenda were perceived as compromising the doctor-patient relationship from the outset:

> I never really had a very good relationship with this lad just cos he never seemed to want to be there; it was always like his mum almost dragging him in. (11; F; 20-29;S)

Raising more sensitive topics when both a parent and a young person are present in the consultation was an additional challenge which some GPs felt defeated by

> ...asking who is at home is not really difficult, I suppose, I am sure I can do it better because I often feel that people are a bit suspicious of me and perhaps I need a better preface of why I am asking them. I haven't really got one for that. (01; F; 50-59;S)

However, those GPs who appeared to engage well provided examples of expert navigation of the triadic consultation. Below is an excerpt from a GP with an interest in mental health who believed that the difficulties seen as 'inherent 'in the triadic consult where 'GP made' and consequently could be rectified as she indicates below:

> Yes there are issues around it but I think often it is almost created by the person trying to have the conversation, than by the young

person; or it's to do with the way that society behaves. So, fair enough, you do get the very rare person that comes in and sits and says nothing....but generally I have found that young people respond incredibly well, just to actually being listened to (04; F; 40-50;S)

Lastly, when a young person chooses to bring a friend, this can be seen by some GPs as being 'tested' rather than as providing moral support for a young person in need. Below an experienced GP reflects on his own professional insecurity.

I recall in the early years when I was new in general practice I used to be quite irritated when a young person would come in with a friend and I used to feel like it was a kind of a spectator sport... then I came to realise that actually for all that we see them as being full of themselves, all, ' cool bravado', they are actually quite diffident in the face of people outside their own groups, especially in sort of formal settings like a surgery... and it's entirely the norm really in the young person's service, for example, for them to come in pairs'. (09; M; 50-59;P)

Dealing with the unexpected

A recurring theme amongst the participants was the unpredictability of young people's behaviour. GPs reported that they both varied as a 'social group' making it difficult to anticipate behaviour and responses for different individuals, but also as individuals; that is to say that their behaviour may vary between consultations and in terms of their response to the GP. The outcome of this inter and intra-variability is that the consultation could be unpredictable and the unexpected might arise.

Early on in the analysis it became apparent that the *modus operandi* of some GPs was more likely to mean that they were better able to cope with the unexpected happening in the clinical encounter, than others. Exploring what this might be led to the delineation of the three axial codes, as this chapter demonstrates.

For a number of the GPs the anxiety associated with young people raising topics about which there might be ethical concerns, and fears about the young person's safety, were a real concern. This particularly related to possible disclosures of abuse.

> *I think one of the big issues is about whether people have been abused in some way at that age and I think that's really hard....and with that girl - I never said anything.....because I never really felt I got enough.. she was too guarded (for me) to go there.* (01; F; 50-59;S)

Whilst many GPs expressed confidence about knowing what to do with a suspicion of abuse involving younger children, there was less professional confidence expressed about how they might manage a similar situation in adolescence. There seemed to be less clarity in this area about the available options for accessing help which seemed fewer.

When dealing with the unexpected there was a sense from the GPs that they were operating in a vacuum which inhibited GPs from becoming more actively involved. The GP below, who had 30 years of clinical experience , talks about a clinical case where she suspected abuse or neglect at some ill-defined level might be happening, but did not feel professionally competent, confident or sufficiently supported to raise the topic in the clinical encounter. Not knowing if and how they should be 'probing' holds GPs back at a time when young people might most need professional help. She speaks about a young woman who attended surgery frequently for apparently 'self-limiting' infection and "some bullying issues":

> *...there was a girl I saw quite a lot at my last practice who was about 15 and had recurrent sore throats but she was missing a lot of school and really it didn't match, and over a period of time there was some bullying issues at school and it was always a bit bizarre . She would sometimes come with her dad, but not her mum, and I kind of wondered what was going on there but never really, I always felt there was something else but I never got there.* (01; F; 50-59;S)

Dealing with the unexpected also includes responding to the not infrequent 'crisis' presentation which is often associated with youth mental health in the family context. The GPs spoke about crisis presentations happening more often with younger people than adults as a source of pressure upon GPs to act quickly, sensing from the family an urgency to intervene. This is described below by a GP who felt pressurized by this recurrent form of presentation.

> *...for the parents it's interpreted as you know my child's in 'this last chance saloon' and you've got to take action now. (*17; M; 30-39;S)

Another GP felt similarly 'cornered' into responding with a direct action which invariably resulted in a hasty referral to CAMHS, usually ending up in a 'failed encounter' with the young person not attending for their out-patient appointment .

> *... you see them at a moment of crisis, and even when you know that and you try to deal with that in a way that's appropriate to a crisis intervention, you still get caught up in the referral process; but I try not to refer from the first consultation, knowing fine well that the next time you see them.* (15; M; 40-49;P).

The phenomenon of crises flaring up and then calming down in adolescence was a source of uncertainty around clinical management that many GPs referred to, regardless of age, gender, or practice population.

> *....a lot of the teenage problems are that they are in absolute crisis one minute , you see them a week later and they can hardly remember what it was all about; and then it obviously wasn't such a crisis but it was to them at the time. And so you want to be supportive but actually if you try and intervene and do anything... it's really difficult so the problems sort of come and go really quickly. (*07; M; 40-49;S)

The pressure to deal with the unexpected and 'do something' is also a double bind for many GPs who lack confidence, since the 'do-ing' options

appear limited. This is in contrast to working with an older patient who presents with mental health problems, with whom most agreed they would adopt a 'stepped care' approach (unless the mental health symptoms were severe enough to warrant an urgent psychiatric assessment). An encounter with a young person seemed to require something 'different'. This is summarized below

> *....if I saw an adult with depression I might start them on treatment and then they come back in a month or two weeks and then two weeks again and see how they went. It kind of feels like we have to have action now (with teenagers), and because we can't prescribe or it is not advised to prescribe for them then I kind of feel that it's, well, pass them on straight away'.* (17; M; 30-39;S)

The sense of operating in a vacuum is problematic for GPs who are looking for ways to deal with adolescent mental health problems and will be explored further in the Discussion (Chapter 6).

Cultural clashes

Cultural clashes refers to the phenomenon of actors in the clinical encounter sharing different norms and expectations about social behaviour.

A theme which emerged from the interviews and *situational analysis* was the difficulty the GPs experienced when they were in a consultation with a young person, and or with their parent, and they were expected to comment or make a judgement on 'what is normal' for this age group. Some GPs described themselves as being in the often unwanted position where they are not only assimilating information from the young person and or parent, but they are also 'asked' to locate it in a broader context of what is 'normal'.

Very few of the participating GPs referred to the inner conflict many teenagers might experience as they in turn decide for themselves what constitutes as 'normal', on a changing landscape of possibilities.

> *So mum had said oh she has dreadful moods on her periods, it's like living with a monster and then um has followed it up with but that's normal isn't it?, she's 14.. and it's often said quite light*

heartedly isn't is......but it could be a cry for help...it's difficult to know. (11; F; 20-29;S)

Questions of judgement regarding determining boundaries of 'normal behaviour' compromised many GPs' confidence in therapeutically engaging with young people. Many spoke of feeling ill-prepared and anxious not to offend and as a result tended to withdrew from exploring the problem. For example, discussing normative behaviour around alcohol consumption proved problematic as questions posed by GPs appeared burdened with moral judgements and not 'neutral' This would occur where the GP was unsure about what constituted 'typical' or 'acceptable' variations of normal behaviour for young people in that particular social context .

> *Yeah I struggle with... if I want to ask a question and then I feel as though maybe the patient will feel as though I am accusing them when I ask that, and I'm not; say I might want to ask them about drug use or alcohol use and those sorts of things that people naturally get very defensive about ... I find that difficult because it's always, well it's often difficult to know how to pitch it. You don't want to overdo the whole ' look this is confidential' side of things... just for a person to say 'no, I don't drink'. (*08; F; 30-39;S.)

Here the GP expresses her experience of tension when one is expected to conduct a clinical inquiry, which, within the biomedical paradigm is assumed to be 'objective and neutral'. However since behaviours arise out of a social context some of the participating GPs felt that their questions were not perceived as 'neutral' but judgemental or even accusatory. The young GP below had been recruited with reference to her practice patch which has a significant problem of drug misuse in the adolescent and younger adult population. She was particularly aware of the moral subjectivity associated with questioning patients about their 'lifestyles' and saw herself as one who was deemed to be passing judgement upon patients; which made her uncomfortable.

> *Yeah so I don't ask everybody if they take drugs so who do I chose to ask?.. I suppose normally if it's a mental health issue I*

115

will ask about drugs and alcohol, if it's a young person I suppose again, I am coming out with massive prejudices now- but I don't ask everybody so I suppose I am making a judgement every time and that's why it's a difficult question to ask. (11; F; 20-29;S).

One of the examples which arose to illustrate cultural clashes was presented by a GP who worked in a prosperous village which also included a Traveller site. He described himself as having become accustomed to looking after Traveller families over the last two decades but still found it puzzling.

*We have quite a few gypsies here and they would appear angry sometimes to me when they are not because they are loud, they are very 'unbritish middleclass', so I find it very hard to interpret their behaviour sometimes. (*06; M; 40-49;P)

Below he describes a vignette in which he confronted a number of ethical and cultural conundrums which can present when operating in a culturally unfamiliar arena. Being unsure about the boundaries of what is 'good practice' and what might be reasonably expected of professional behaviour, resulted in his own unresolved internal ambiguity about the best way to proceed, and he described himself as operating in an area where there are no 'guidelines on best practice'.

*...she looked about 17 but she was 13, and she came on her own 2 or 3 times and talked about her father's anger; they live on the council estate round the corner & the father is of gypsy stock .. she came to see me and she was very upset about her relationship with her father. She was refusing to go to school and he was shouting at her and dragging her out of bed to go to school, and I had all sorts of mixed feelings about ' well she is not telling me he has hit her'.., I could almost see myself with a teenager child in the same circumstances, which isn't a way of saying they're right or wrong but creates all sorts of discomfort as how would I behave if I was him'. (*06; M; 40-49;P)

Unable to decide what to do; divided between wanting to take action as the young girl was wanting him to do and challenge her father, and at the same time feeling ambivalence and empathy for the father's frustration, he sought his colleagues' advice who recommended involving child protection services.

> *And I referred it and he ended up coming to see me, late on a Friday night and being very angry and I felt a bit scared, and the child protection came to nothing and I think I shouldn't have felt, I had nothing to feel scared about - he acted like a slightly angry gypsy would act. He didn't hit me, he shouted at me, told me "I was useless, it was normal behaviour" and what would I do if I had a daughter like his? .. and all those thoughts had been through my mind previously and I had the vaguely embarrassing feeling of he was right. (*06; M; 40-49;P).

This candid account of a less than successful professional clinical encounter illustrates appositely the competing tensions GPs experience when they traverse socio-cultural boundaries. In such scenarios there are no hard and fast guidelines or protocols and GPs are left reliant on their own repositories of professional and personal experience, with their own judgement the deciding arbiter.

The role of social class in augmenting tension in the clinical encounter was not a subject GPs raised spontaneously. The theoretical sampling process included GPs working across the socio-economic spectrum but all of the GPs can be assumed to be 'middle-class' by virtue of their education, income and professional status. One GP described herself as of 'working class' origin and discussed how this impacted on those consultations which crossed social class boundaries. However she acknowledged that as she moved further into her professional career she responded to the social encounter of the consultation 'more as a doctor' and less as 'an individual'.

Another GP admitted that he was much happier consulting with parents (of troubled adolescents) who shared a similar social background to himself and of being able to discuss the options of care available on "a level playing field".

117

> *.....for example, teachers, nurses,....sort of caring and educated people and that makes it you know, you find you have much more level conversations with them, so much more negotiation and stuff and working with the family and you sort of share their frustrations really with the system, the inadequacies of the system.* (07; M; 40-49;P).

He felt that in contrast such a dialogue would not be possible with parents of "a lower socio-economic class" where there is less shared common ground, leading to a lack of empathy and introducing frustration into certain consultations, underwritten by a mismatch between patient and doctor expectations. This discordance is also seen between a GP and their patients, including young people, where the young patient lacks cognitive capacity and inhabits a different social context to their doctor:

> *...this is an awful thing to say but if he's intelligent as well as got problems then they are sometimes easier to deal with, unlike this young man who has got educational problem. He drinks and he is violent but he still comes to me for help but he won't, he can't stop doing the things that he is doing and maybe that creates in me some of the feelings that I think I have and most doctors have around the people that we most want to diet and the people we most want to stop smoking and they can't do and we feel frustrated and think if I'm really honest I get a little bit cross with them cos they won't do what I want them to do and that doesn't help that, I don't act upon it but even the feeling doesn't help'* (06; M; 40-49;P).

The participating GPs varied in how important they considered it was for them to be familiar with the social landscapes of young people. Those who had difficulty engaging with emotionally distressed young people tended to dismiss 'the background information' as of marginal interest, in contrast to those who described themselves at ease communicating with young people and who had a working knowledge of 'youth culture'. A familiarity of this context made these clinical encounters less challenging and less likely to be

perceived as traversing cultural boundaries which often compromise the doctor's sense of professional integrity.

Perspectives on young people and their health needs

The second pillar (or axial code) which was found to influence a GP's readiness and commitment to engage with young people presenting with emotional distress concerns how a GP views young people and their particular health needs.

Below is a table which presents the open codes contributing to the development of this pillar.

Open codes contributing to perspectives on young people and their health needs

Different or on a continuum?	Developmental spectrum	Trust in the doctor-patient relationship	Duty of care	Adolescents and agency
A separate group	Vary in degree of maturity	Concerns about confidentiality	Young people can be vulnerable	complex
On a journey	Vary as an individual over time	Getting to know the doctor	Need a timely response	dynamic
'Difficult communicators'	Emotional lability	Time	GP taking responsibility	Requires knowledge of context
Have particular needs	Understanding how consultations 'work'	Finding common ground	The function of the family context	Professionally Challenging
Developing along a spectrum		Sharing a language		
Being embarrassed or uncomfortable with the GP		Difficulty opening up		
The importance of the social context				

The key finding was whether or not a GP considered young people to be part of a 'sub-group' or separate 'social category' or whether they were viewed as people/patients on a life journey. All other characteristics in this category followed from this initial position.

Beyond this binary position other features were found in the analysis which substantiated this second pillar. These included whether or not a GP has an understanding of the complex developmental processes implicated in adolescence; the GP's view of the importance of trust in the doctor-adolescent patient relationship; the role of a concept of 'duty of care' and showing compassion towards young people in distress; and finally, an understanding of adolescents on a spectrum of 'agency-dependency' would shape a GPs' degree of engagement. Each characteristic will be dealt with in turn.

Young people seen as being on a life cycle continuum or as 'a species apart'

A GP's view of young people as being on a life's journey or as being part of a socially distinct and separate group appeared to fundamentally influence the GP's likelihood of wanting to engage with a young people. Seeing a young person as an individual with a life history, containing both a past and a future, appeared to lead to a qualitative difference in the consultation when compared to those GPs who saw adolescents as something 'other' The latter position was adopted by seven of the participants with one of its most frankest exponents speaking unequivocally below:

> *I think myself, and probably a lot of other doctors, find that a sullen sulky brooding teenager probably one of the most difficult patients to deal with.* (15; M; 40-49;P).

This same GP, who admitted candidly to being relieved when a teenager left his consulting room, construed adolescents as "reluctant communicators" and believed that the onus on an open dialogue lay with the young patient and not the doctor, whom he viewed as operating equally with all patients.

This position was contrasted by those GPs who recognized that teenagers might sit in a group separate from others because they have particular heath needs. Where GPs took this view they demonstrated higher levels of engagement. This was the position expressed by seven of the GPs and is articulated below by a GP who felt that young people have been let down by a primary health care system which has not always considered their perspective and which has often shown teenagers a "shut door"

> It is a continuum but I do think also that they are probably a different group, I think, but you know as you say it's all part of the general practice, I mean, there are lots of little groups within this whole general practice really, but I think **they** are a group that perhaps are slightly neglected. (19; F; 40-49;P)

This was a view expressed with reservation and a sense of regret but it was not one expanded upon by other GPs.

At the other end of the spectrum were a group of five GPs who did not see young people as a group apart but as individuals with their own histories and needs.

> ...no, they are not a different group. (18; F; 40-49;P)

This group of GPs which comprised two younger women, two women in their forties and a male GP in his late forties saw young people as going through a period of transition not dissimilar to other periods of adaptation in a patient's life. Such examples might include the diagnosis of a long term or incurable condition or a woman approaching the end of her reproductive life and facing 'empty nest syndrome'. The GPs populating this group spoke of a much more collaborative approach to their history taking and of a desire to 'centre-stage' the young person's life story, within the context of their family. The extract presented below summarises both what is similar and what is different about adolescence and other life transitions.

> I think they go through a difficult time in their life in terms of hormones and family and are becoming more independent and I can see all of that and those are difficult and challenging times for

121

them as individuals and them as a member of the family and that
makes them special, their needs as a individual. But that's
perhaps no different to a woman coming towards the end of her
periods and going through menopause and the kids leaving home.
It's just a different set of circumstances perhaps with not dissimilar
*needs. (*18; F; 40-49;P)

Another GP member of this group believed that viewing adolescents as 'a group apart' was an unhelpful, 'labelling' strategy which compartmentalized patients into sub-groups and over complicated consulting which should be an essentially human interaction. She believed passionately that 'pigeon-holing' people was detrimental to therapeutic clinical encounters

It's the same with everybody that walks in. It's not just about
young people, it's about what are the influences on that person's
life? I don't present young people any different, to anybody else
cos they are just people; you know five year olds are people, nine
month old babies are people....knowing the context of that person,
it may be harder to bring that out in some groups, maybe young
people's one of them. (04; F; 40-49;S).

However, this was a minority position and most GPs did view young people somewhere between 'having different needs' to 'being difficult to comprehend'. The further a GP was along the spectrum towards seeing young people as 'being different' the more they were likely to objectify the teenager as 'other' or 'alien'.

Analysis of the data showed this position could lead to two consequences. Firstly, GPs seemed to see this as an absolution from assuming a responsibility to try and communicate, with the view being that because 'they are different' they are *de facto* 'reluctant communicators'. This position appeared to shield the GP from taking responsibility for their part of the interaction. The second finding was that when GPs saw young people as 'other' they distanced themselves from their patients which reduced the chances of compassion and curiosity developing naturally. This was in contrast to a spontaneous sense of human interest arising out of a mutually

trusting relationship, which GPs who engaged well with young people shared.

The data showed that viewing young people as 'distinctly different' erects a barrier which works against promoting trust and prohibits against therapeutic involvement with a young person in distress.

 Understanding the developmental process of adolescence

The GPs recruited in the study displayed a range of views regarding their awareness of the significance of the development processes which can occur during adolescence. The early open codes revealed that the range of emotional and physical maturity seen amongst adolescents of the same age was a cause for concern amongst GPs who were very often being expected to make decisions about a young person's   emotional health when their chronological age was only one element of the picture. The disparity seen across physical, cognitive, social and emotional axes of maturation places additional challenges upon a GP's grasp of the presenting problem and influences how they construct their response.

> *I mean I think overall I'd probably describe it as challenging because they're quite a variable group in terms of their maturity....then you get, say, quite different ones, some of them still very much look to their parents but some of them are really very independent and come on their own and that's fine, they don't mind, just happy making decisions on their own.* (17; M; 30-39;S)

This variation in maturity appeared to place more emphasis on the GP to determine their own response for each individual case, as shown below:

> *....she came in on her own and was incredibly articulate about her problem and that felt alright ....but I think quite a few people would have said you can't come in on your own - she was only just 14 but she was as mature as many16, 17 year olds really so, I'm not sure its age but their maturity probably.* (03; F; 50-59;P)

An understanding of adolescent behaviour and its drivers appeared more pronounced in those GPs who had adolescent children or experience of

parenting adolescents; although there was a great variability in how ready the GPs were to discuss their own experience. Only four participants referred explicitly to their experiences of parenting adolescent children, two others made oblique references to the use of the internet and had younger (pre-teen) children. The extract displayed below is the most vivid in its acknowledgement of the role which knowledge gained through parenting can contribute:

> *I think it's easier having kids of your own and knowing their own little foibles and knowing the significance of a 'yes and no' answer; that they don't usually mean what they are actually saying and their expectations are slightly different and time spans and demands tend to be much shortened, you know, they are wanting a response immediately to most things. (14; M; 40-49;P)*

However, the small number of GPs who did refer to their own experiences observed that one's own experience might be conflicting and reduce 'objectivity' (see below) suggesting that many GPs do not easily or readily draw from their own lived experiences.

> *I think it does help because you have been in the situation a bit more so perhaps you can relate to it a bit more, but then you've got to be careful you're not bringing all of that in, or whatever. (19; F; 50-59;P)*

A female GP who was the mother of two teenage boys commented that being a parent in itself would not necessarily confer an enhanced ability to engage with young people as it would be influenced by the nature of the relationship the GP-parent enjoyed with their own child

> *I don't think it's about having children particularly ...it depends on what sort of relationship you have with them. (03; F; 50-59;P)*

Personal experience might come from contact with young people through the extended family in which case it was portrayed as a positive and transferable knowledge, useful in the consulting room

I think, I feel I can interact relatively well with them, I have quite a good experience within my own family, a wide range of nephews and nieces and this type of thing so I am used to what the current 'in' things are and that type of thing, so I think generally I find it quite easy and I think I am relatively approachable. (16; F; 20-29;S)

Those GPs who manifest a broad understanding of the developmental changes young people experience were much more likely to adopt an empathic approach and cultivate a curiosity concerning what might be happening for the young person in their world. Being able to imagine the multiple demands upon a teenager appeared to be an important bridging device to encourage the GP to begin a dialogue with a distressed young person:

I suppose also, obviously, it is a difficult time being a teenager with all the life choices; do I want to go uni or don't I?, or, relationships in their lives and just becoming independent. It's a time when I think mental health problems are quite common aren't they or at least stress is quite common. (11; F; 20-29;S)

Conversely where a GP felt uncomfortable with a young person's demeanour, particularly where they felt challenged by it, and did not see it as possibly relating to a lack of self-confidence, a tension would arise in the consultation which could negatively impact on the doctor-patient relationship.

Endeavouring to understand what might be happening from the young person's perspective promoted compassion on the part of this doctor and also aroused his or her curiosity as to what contextual factors might be leading a young person to seek help at this time. A number of GPs spoke of exploring 'the background story' and did not consider a young person's behaviour as a constellation of symptoms arising out of a vacuum. They were keen to hear from the patient and to weave the story into the young person's own social landscape without jumping to assumptions:

...cos often with I think adolescents it's not what they are presenting with but why, why are they coming now, and I am always very aware of that... and I think I often use reflection a lot, "you seem really anxious and stressed today", or "you seem really down" and I just say that and see how they respond. (05; F; 20-29;S)

The importance of trust in the relationship

One area where there was a clear consensus concerned the importance of trust in therapeutic relationships with young people and their GP. This was considered to be qualitatively different than when a patient was an older person and seemed to stem from a position that older patients were more likely to uncritically trust in their doctor in contrast to young people

I think confidentiality is an issue for young people, so trust, I think trust is different I almost feel I have to earn it more with young people, whereas with adults they give you that more freely. (01; F; 50-59;S).

As in this extract, trust was presented as inextricably linked to confidentiality which was also identified as a key component to forging a therapeutic relationship with troubled young people and singled out as an area which needs particular consideration for adolescents.

I do make it clear to them that their parents won't.... often they know that I know the parents and look after the parents and I do make it very, very clear that the parents will not be told and I do find it amazing that young people still don't know what confidentiality is, they almost seem surprised by the fact that you won't tell their parents. (15; M; 40-49;P).

The majority of GPs spoke of the notion of building up trust over time as an active process and were aware of young people's need to 'test' or 'try out' a GP before they were ready to disclose sensitive information. The GP quoted below saw a larger number than average of patients of all ages with mental health problems and spoke of the on-going process which happens when a

consultation is split up into ten minute chunks. Seen over numerous occasions trust is acquired and banked, like other forms of capital.

> .....you've got another evolving relationship within that consultation between you and the young person and that will change their perspective of what they need and want at any point; and there is trust developing and there may be things that they do trust you with , you know, it is that continuous process. (04; F; 40-49;S).

Those GPs who saw young people as on a life journey and having particular needs, shared examples of vignettes which demonstrated how trust was earned and validated before young people would share intimate worries or anxieties. This is shown below by a GP who appeared attuned to young people's perspectives but at the same time was honest about his difficulties in knowing what course to take at times. Below he speaks at length about a young woman who consulted him on a number of occasions but only after three or four months was she able to talk to him about her self-harming behaviour:

> The first time she came was about her acne and it was about three months after the death of Princess Diana and she said "oh by the way, my mum has been saying I'm getting too concerned about the death of Princess Diana. I talk about it too much.... it's always on my mind"... She had been self harming for a couple of years and she tried me out for three or four months before I found out about the self harm. (06; M; 40-49;P)

But even before a relationship can develop with a young person there has to be a point of connection and those GPs who tended towards active engagement with young people spoke about this, again as something qualitatively different when compared to their relationships with older patients. A female GP spoke of actively seeking a point of connection with her younger patients, although she recognized that in all good consultations with patients, regardless of any age, finding common ground would improve the quality of the interaction. Below she refers to a patient who might have

been called a 'reluctant communicator' (15; M; 40-49;P) but with whom she invested time and energy and built up a trusting relationship:

> *I see somebody she must be now in her late 20's, and we chuckle over how she wouldn't talk to me when she was a teenager, but, she did keep coming, although she, it, felt a very one sided consultation... very much doctor led, she would come back and she would try and put things into practice that I had suggested and so although she was a reluctant patient, she did at quite a big level take things on.*

> *She was very interested in art, so I asked her to keep a diary, an art diary, but it's not saying it's based on medicine, in fact it's just based on caring and plucking an idea from the middle of the air isn't it?, or trying to get a meeting point.* (18; F; 40-49;P)

Another male GP spoke of his understanding of how young people invest in the 'doctor-patient relationship' by referring to examples where he had, on reflection (after the encounter) realized that the young person had been 'testing ' him in order to see that it was 'safe ' to continue investing in the relationship.

> *I think young people often come and try you out with bits and bobs so, a girl came to me for contraception for a while before I found out about her other problems... she was re-doing some exams and each time she came she started talking about the book she was reading and because she was doing English she was talking about some of the classics, some of which I had read and I found that she was sort of not just talking about the book but she was talking about her interpretation and asking about my interpretation on life. And I thought it was fascinating; that it was more than, she wasn't just testing out "will he listen?", she was testing out" is he good enough? does he understand?" and I don't know whether I would pass any of that.* (06; M; 40-49;P)

A "duty of care"

There was a spectrum in terms of how the participating GPs spoke of their responsibility to look after young people. Those five or six GPs who gravitated more towards considering young people as being on a life journey were much more likely to speak of their duty to look after adolescents who where displaying signs and symptoms of emotional distress; than were those who saw them as a group apart. There was also a recognition that their age conferred a certain vulnerability and hence the responsibility of the GP to younger versus older patients was different.

The importance of responding in a timely fashion was also seen as critical. One GP articulated the risk of not responding at the time of need as potentially being capable of dissuading a young person from ever seeking help again:

> *I think with young people that's even more important, I think I just have this fear with young people that if one person fails to listen that could be the end of it all and so if they need 30 minutes that's absolutely fine whereas if I spent 30 minutes with an adult I might feel a little bit more as though that wasn't such a good use of my time perhaps... but I do feel with young people I would always give that bit more time. (*08; F; 30-39;S)

Another stated:

> *I think that perhaps there might be more of a duty of care to somebody who is 14 than somebody who is say 34. In terms of if a 34 year old said they didn't want to do something even though I thought it was a good idea, then I would work with that, that would be fine; but if a 14 year old didn't then I may feel that although I judge them to be competent, I actually feel a bit uncomfortable about it. (*18; F; 40-49;P)

The majority of participating GPs shared vignettes illustrating examples of care which they had been involved with. The vignettes often crystallized ideas and thoughts which were not always easy to articulate and in 'the

vitality of practice' (Farmer, 2001) revealed areas of importance and concern for those GPs who felt that young people had not always been best served by existing models of general practice and 'shared care' .

Below is a vignette of a case study involving a relatively inexperienced GP and a 15 year old girl, living with her grandmother, who had a history of 'running away' and who presented to her GP acutely distressed. She had been referred urgently to CAMHS but their response had been tardy and the GP remained in a state of high alert and concern for the vulnerability of her young patient.

> *But you know if I hadn't of spoken to the gran, and if I hadn't kept reviewing her, so I would ring her or see her everyday. The teachers at school were aware of the problem so everybody, you know, we all kind of pulled together to try and support her while we were waiting for the expert help. And you know I think the reason that she didn't jump off the cliffs was because me, the teacher at school, and the gran were - and yes they did have to get the police out one night - they were looking for her with the helicopter and things and yes she was on the cliff tops but, at least everybody knew what they were doing and kind of pulled together with it.* (05; F; 20-29;S)

This case study offered perhaps the most explicit example of a GP taking their responsibility seriously in the face of a structural barrier from secondary care who took over a week to respond to the urgent request; in contrast to the referral of an adult under similar circumstances who would be seen within 24 hours. The GP in question was angry at the response from CAMHS and lodged a formal complaint.

Such a degree of attentive care was most clearly seen by the group of GPs who considered young people had particular needs, rather than were on a life journey, and who most closely played the role of advocate. They were cognizant that distressed young people often had to be asked direct questions in order to determine their level of psychological morbidity and

could not be relied upon to articulate their level of distress in vocabulary that was familiar to a GP; as seen below:

> *I think sometimes the younger patients respond a little better to direct questions because I think they don't necessarily know how to put things across.* (16; F; 20-29;S).

Those GPs who practiced with a sense of a duty to care for young people took responsibility for asking pertinent questions on the basis that:

> *If you don't ask them, they won't always tell you.* (05; F; 20-29;S)

GPs who categorized young people as belonging to a different group were less likely to make the effort to find the vocabulary that would make sense to the young person; thus leaving them potentially alone in their distress, and even more isolated.

Adolescents accorded agency

> *'Agency is the capacity of human beings to affect their own life chances and those of others and to play a role in the social realities in which they participate'* (Kapferer, 1997)

The concept of young people as having agency, in contrast to being dependent upon their parents, is complex and dynamic. To discuss this element of a 'GP's view of young people' is also to refer to other characteristics of this axial code, including the developmental trajectory of adolescence and its intersection with societal and familial expectations. The key finding here was that GPs relied upon their clinical, professional and to a lesser degree, personal experience to shape their understanding of adolescent agency. The more they had contact with a variety of young people, living in a range of circumstances, the more they were able to distinguish the range of possibilities .

The less contact and engagement they had and the more they saw a young person to be 'different' and 'difficult', the more likely they were to see the individual as the architect of their own life history.

I think one of the things is that sometimes you don't feel like, like with this lad cos he had always been swearing and like almost made it clear he didn't want to be there; that that was a barrier to me cos I felt, I almost didn't offer what I would normally offer cos I assumed already that he was going to kick off, and that was wrong. (14; F; 20-29;S)

The GP here admitted to a set of assumptions about this young man and his apparent 'unwillingness' to talk in the presence of a parent. In a later consultation, after she describes him being marched in to the consulting room "like exhibit A" her invitation to talk without a parent present provoked a totally unexpected conversation

*we had a chat while she (mum) was there and I was really trying to engage with him and say 'how do you feel and of course I want to hear it from your point of view' and then he said, 'do you know what, I feel angry all the time'. And I thought 'wow, you know actually he is kind of talking about how he feels', fantastic so I asked mum to go out. And we were having a chat and he just opened up amazing, completely.. I think that was my prejudice that he wasn't going to, but he did.... cos he had always been swearing and like almost made it clear he didn't want to be there that that was a barrier to me cos I felt, I almost didn't offer what I would normally offer cos I assumed already that he was going to refuse and that was wrong. (*11; F; 20-29;S)

For the GP, hearing from a young man of 15 who had lost contact with his biological father (who no longer wanted to see his son after starting up a second family), who had been introduced to smoking cannabis by his mother's partner and who was accused of being ' difficult' by his mother, his story was a revelation. She had assumed that his hostile demeanour towards her was a conscious rejection of professional involvement. By inviting him to talk on his own terms she learnt about what was really bothering him and of the myriad of competing tensions in his life.

Some GPs were more attentive to the complex psychosocial contexts of their young patient's lives.

A teenager's lot is a tumultuous lot. (14; M; 40-49;P)

Below a GP demonstrates an understanding of the backdrop to a young person's emotional distress

> *Yeah and I think because of the experiences that have often led them to have mental health problems, you know, that there might be difficulties in their lives; ...living between the mother and their father or that they're ..frequently truanting from school and that takes them off in all sorts of directions and so getting to a doctor's appointment is not.. difficult maybe the wrong word, but not so high on the priorities, not really on the agenda as much. So I try and encourage them not to behave in that way but at the same time I sort of appreciate that yes it does happen.* (08; F; 30-39;S)

Understanding agency is further complicated by the influences of socio-economic factors. In general the participating GPs showed low levels of interest regarding how social class impacted on young people's mental health and 'the bigger picture of the political landscape'.

Only four GPs in the sample, all of whom worked in areas which served low income and disadvantaged families referred to the wider influences of socio-economic constraints upon emotional well-being. Only two articulated this relationship to any degree of depth; one of these GPs had a particular interest in mental health. She refers to the sense of disempowerment which many young people experience compromising a feeling of agency about one's own life:

> *...that's the big issue, often young people are coming in with a sense of being powerless. No wonder they are frustrated, with life and the universe, society; it's about this value thing - society has made them pretty powerless. You go through the education system - you do this apprenticeship - because that's what you*

> *should do... so they are often within a sort of powerlessness. (04;*
> *F; 40-49;S)*

This GP alone drew attention to the popular narrative of young people being 'demonized' and contrasted this with the way adults are allowed more options

> *... thinking about young people - what do you see in the media,*
> *generally, it's, drugs, alcohol, suicides, so you're either highly*
> *intelligent and get bullied and commit suicide or you're just out of*
> *control and impossible and have to be contained in some way. You*
> *know? We don't view the adult population like that. (04; F; 40-49;S)*

She concluded that there are enormous pressures put on young people whilst at the same time they are not often offered sufficient and timely support:

> *...we don't just pile that on them as young people, we start from*
> *birth upwards - pulling away the factors that can allow them to self*
> *resolve, and putting on the pressures that increase the distress. I*
> *think young people are remarkably resilient and part of that is the*
> *very behaviour that we complain about as a society, they are to a*
> *degree protecting themselves; it may not be a constructive way*
> *but it's effective for a lot of people and it gets them through when*
> *society isn't supporting them. (04; F; 40-49;S)*

Epistemological frames of reference

Having identified that a GP's performance in the clinical encounter was important, in parallel with how they viewed the perspectives of young people, a third area of influence upon GP engagement with young people was identified.

This third pillar, that is to say the third and final axial code, refers to the epistemological frames of reference or knowledge frameworks which GPs draw upon to underpin their practice of medicine. This axial code also takes into account the earlier analysis which identified structural constraining and

facilitating influences upon practice. Using the analytical construct of GP engagement it was possible to plot out a framework based on the epistemological underpinnings which appeared to inform each of the GPs' accounts of their practice.

Below is a table presenting the open codes which led to the development of this third and final pillar of the theoretical framework.

Open codes contributing to Epistemological Frames of Reference

Biomedical Paradigm	Biological-Biographical Paradigm	Interpretative Paradigm
Rationalist view of illness	Context is important	Context is important
Disease as verifiable entity	Emotional distress has psycho-social origins	Emotional distress has psycho-social origins
Depression in young people a category	Family medical history important	Patient's history is a narrative construction
Focuses on the individual patient	Incorporating external guidelines and recommendations	Power distributed between doctor and patient
'Somatization 'masking depression		
Accords agency to the young person	Doctor shapes plan of action	Recognized the contingent nature of life
Diagnosis and appropriate responses are paramount	Trust is helpful	Establishing trust is critical to good practice
		Relationship centred care is at the heart of good care
		Empowerment for patients is an important goal
		Critical of the wider societal factors

Introduction

Firstly, the analysis of the data demonstrated that under-pinning clinical practice are the paradigms of knowledge which inform how illness is understood. Knowledge is accumulated through medical school experiences of undergraduate medical education and is then subsequently informed by clinical and professional experiences, added to by life experiences; including perhaps as a patient, carer or parent. Secondly, understanding where each GP positioned themselves with a view to paradigms of illness allowed an exploration of how the GPs talked about their role with regard to responding to emotional distress in adolescents. This would feed directly into the development of the over-arching explanatory theory which examines the plurality of roles GPs occupy in this clinical arena.

The participating GPs occupied a range of epistemological positions along a continuum and although these positions are not fixed, the accounts of the GPs suggested that most people tend to occupy a favoured position. The continuum has two poles. At one end is the Biomedical paradigm and at the other end sits the paradigm of Interpretative medicine.

The mid position might best be described as the biological-biographical perspective which prioritizes the accounts of individual patients within the immediate context of their family unit and local community. This is where the majority of GP participants could be grouped.

Each of these paradigms draws upon different sources of knowledge including propositional, procedural, embodied and tacit knowledge and views the use of professional power differently. This chapter will articulate in detail the defining features of each of these positions, along the continuum, and present data from the interviews as illustration.

The Biomedical paradigm

Western Biomedicine is the dominant cultural system, which underpins every medical curriculum in the UK. However, as an epistemological frame of reference for practising clinicians its relevance can sometimes be contested, especially for those working in primary care whose work load comprises so

many medically – unexplained symptoms and manifestations of psycho-social distress.

Biomedicine supports a rigid and hierarchical classification of expressions of mental illness which includes psychiatric disorder in children and adolescents, and supports pharmacological approaches to treating mental illness. This study aimed to explore how GPs made sense of psychological distress in young people and so it was to be expected that a number of participants would subscribe to this paradigm. In total five GPs made statements, offered vignettes and described their approaches to practising medicine in accordance with the biomedical paradigm

With regard to adolescent mental health, amongst these GPs there was a view that 'depression' exists as a valid disease category which could be screened for and identified and was a GP's responsibility to identify and refer into secondary care.

> *If it's truly depression then it's not really different (between younger and older patients). I think there will be biological depression that has started early. I think we haven't really talked about you know early psychosis and where you might pick that up, that sort of thing......*
> *If I think its depression I think it's the same illness, but perhaps sometime harder to tell whether it is depression or not in young people.* (01; F; 50-59;S.)

The GP presented here is categorical in her assertion that depression as a disease has an external and verifiable validity. This was the view of the small number of GPs in the sample who operated within a positivist realist world view and who did not contest the validity of 'depression as a disease' model, as a favoured framework for understanding emotional distress in adolescence. However, because treatment options are concentrated in secondary care including access to psychological therapies, there appears little designated function for GPs.

*If I thought a teenager was depressed, I wouldn't ordinarily be starting them on an antidepressant without maybe involving the Transition Service (CAMHS), whereas you would not dream of doing that just for an 18 year old or 19 year old plus, you would just start them on an anti depressant if you felt that that was warranted. (*15; M; 40-49;P)

This remark was made by a GP who admitted to experiencing great difficulty communicating with young people, which was not helped by a recent 'teen drop-in' clinic opening up in the practice, run by the practice nurse. His observations of those attending the clinic had been that the attendees were the

... sort of bold brash girls, rather than the sort of the timid, quiet emotional types. You know the ones that you could almost tell are probably trouble at school, erm..., just by some of their behaviour in a medical clinic, which is very inappropriate. I mean it's quite alarming, and these are not 12 and 13 year olds, these are 15 and 16 year olds and some of their behaviour is quite appalling. (15; M; 40-49; P).

His view around medication in this age range was not that it might not help but that it was not endorsed as 'good practice'. This view was shared by another GP:

NICE guidelines a few years looked at depression in young people & kind of hampered our ability to do anything with them really. (07; M; 40-49;P)

However, even where a GP did consider 'depression as a disease' their confidence in the role of screening for adolescent depression was muted, in contrast to the way most GPs described having wholeheartedly accepted the recommendations to screen for adult depression.

On the other hand, when it comes to children you don't have the whole delirium - dementia question there so perhaps you don't need that (screening); maybe you just know that if there

is something that looks like it might be a mental health problem there will be something you can see and then you just need to explore it a little bit and probably refer it on.... I really am very limited in what I can do and the best I can do is pick it up and a screening tool might not necessarily allow me to do that. (08; F; 30-39;S)

That considered, the five GPs in this category admitted that whilst 'depression' did exist, its usefulness as a disease category in adolescence was less convincing and teasing out emotional responses to life versus identifying 'disease' was taxing; as indicated below:

*Yeah because they can all be a bit miserable at times, you know, and all it takes is an evening of listening to Nirvana and anybody would be ready to slit their throat, so trying to get through that sort of self centred.... sort of almost 'acceptable hopelessness' that a lot of teenagers have or go through: they would call them 'Emo's' wouldn't they?....And every class has a section of 'Emo's' and how many of these people are clinically depressed ?or "going through a phase?" (*15; M; 40-49;P)

Even the doctors who practised within the biomedical paradigm recognized that context has a role to play. One of the five GPs spoke of the distinction she might make between talking with a young person who describes a low mood in a clinical setting, and contrasting this with a similar conversation in a domestic setting. In the former case she recognized that she was likely to pathologize the distress and call it 'depression'; in the latter to see it more as secondary to 'personality' or 'life events'.

...*and I do think that's more difficult to unpick sometimes whether I think they are depressed or not. I think in the surgery I would probably say they are more depressed but from talking to my own children and their friends and things and seeing what they're like and how other people have viewed them, I would say they are not necessarily "depressed".* (01; F; 50-59; S)

Deliberate Self-Harm

The practice of Deliberate Self-Harm (DSH) was discussed with all of the participants. The term was used inclusively to mean self laceration or 'cutting', taking an overdose or other form of self-poisoning or any other self-destructive or injurious behaviour which caused pain (although it mainly referred to 'cutting'). Talking about this phenomenon often offered another window into how a GP viewed the signs and symptoms of psychological distress in adolescence and it acted as a proxy indicator for their framework for understanding emotional distress. For those operating from a more rationalist standpoint with regard to mental ill-health the fundamental position on DSH was one of incomprehension.

> *I don't understand, like I just don't understand why deliberate self harming has become so 'popular'. ....I think they are probably reluctant communicators these teenagers, as many of them are. I think the 'Emos' are probably no different really, erm, I mean they are probably reluctant communicators with doctor. (*15; M;40-49;P)

This GP conveyed a view that DSH, in the form of self-laceration, was inscrutable and 'mysterious'. He spoke of using 'the ruse' of measuring blood pressure as a means of examining fore-arms surreptitiously and was uncomfortable openly discussing the practice with young people in surgery . Other GPs in this group tended to take a 'matter-of-fact approach to DSH and accept it as 'mainstream teenage behaviour'.

> *It's obviously incredibly common in certain young people, I suppose in females more so. I think many years ago it would have been a more worrying symptom, whereas now it's almost, in many sort of groups of young girls, that its almost common, normal behaviour in a way and not actually, I think, meaning anything great psychological distress.* (03; F; 50-59;P)

DSH as a 'case study' will be offered in each of the epistemological frameworks to illustrate how GPs, clustering under different theoretical shelters, saw the phenomenon and how they responded to the behaviour according to their knowledge framework.

The Biographical-Biological paradigm

The most populated domain was the 'the biographical-biological' paradigm; a concept first introduced by Armstrong (1979) and more latterly developed in the writings of Heath (Heath et al., 2009), (Heath, 2011). The 'biographical-biological' perspective sits in the middle ground on the continuum of epistemological frames of reference. It is a perspective which considers that most psychological distress in young people (where it is not of a psychotic nature) is largely psychosocial in origin. It also prioritizes the family context. Such a theoretical position acknowledges the intertwined relationship between a young person and their social context.

Ten GPs appeared to sit within this domain. The analysis of their transcripts showed four topic areas emerging as important in understanding how these GPs came to understand emotional distress in young people. These can be summarized as:

- Early life experiences

- Situational factors: 'Life Events'

- Environmental factors

- Formulations of emotional distress

Early life experiences

GPs working in the biographical-biological paradigm were forthright about the role of the family in young people's emotional development.

> I am passionate about children and families and the importance of
> family and its core to family practitioners, and I think it's the core
> building block of society. (10; M; 40-49;P)

This GP later enlarged upon his view of the family as the matrix:

> Unquestionably family is important, you know I will often use a
> genogram... you've got dad who is violent with the partner, yeah.
> But that often comes out when you do your genogram. I mean I
> will often go away if it's a complex case, I will get out all the notes

141

> *you know look at mam's notes, and realise 'oh gosh she had*
> *mental health problems and she was a school refuser' and so it's*
> *about a big jigsaw. (*10; M; 40-49;P)

GP (10) talks of his experience of working for more than 20 years in a community marked by uniform social disadvantage. His acceptance of the inevitability of the interlocking pieces contributing to a person's biographical and biological narrative is contrasted with the words of a less experienced GP, quoted here. She expresses a tension in acknowledging the centrality of early childhood to subsequent psychological well-being, whilst at the same time drawing attention to the past makes her uncomfortable because it suggests making a judgement upon parents

> *I've always very strongly believed, I know that there is obviously a*
> *lot of evidence out there for the effect of the early childhood years*
> *on somebody's general health but particularly mental health, and*
> *so am always very conscious of that but ... I suppose that, going*
> *back to difficult things to talk about, that is something that is*
> *difficult to talk about because you then feel as though you are*
> *laying blame on parents for the way that they've brought the child*
> *up, in terms of how a person then is. (*08; F; 30-39;S)

Given that the same GP may well be responsible for the parents' care, as well as the adolescent patient, the statement indicates the added tension such a belief creates.

The role of family in shaping young people's early development was raised by a number of GPs who recognized the importance of contextual factors in moulding the plastic neuro-developmental processes occurring during childhood and adolescence. Those GPs who framed child and adolescent distress within the biological-biographical paradigm saw a link between family context, early development, and epigenetics,as suggested below:

> *.....because to me their behavioural problems is a reflection of*
> *another problem going on, so it's often a reflection of family*
> *dynamics or some issue with, I don't know, bullying or stressed*

about something. So I see the behavioural problem as a result of something else and not that it's the problem on its own. I know with ADHD, people would argue that it's "a medical condition" that results in their behaviour which is fine, but I think children with ADHD are coped with in different ways, by different families. (05; F; 20-29;S)

However, understanding the role of parenting and family dynamics in children's mental health does not necessarily offer an obvious solution or indicate the best response a GP can make. Initiating a dialogue about parenting practices in a consultation can be problematic, as is shown below. These are the words of an experienced GP who still found such clinical encounters difficult .

....and you then have the unsatisfactory feeling as well- "I am potentially going to fob these off, to a child and family psychiatrist, and they do an investigation into it, knowing full well that all that's going to be said is "well, no, he hasn't got ADHD, he hasn't got this, and hasn't got that ; it needs a bit of parenting,"... and sometimes in 10 minutes you can't really explore what the problem is and are we really qualified to say "well, you know, do you think it is a parenting problem if the teachers are fine with him?" (14; M; 40-49;P).

Situational Factors: Life Events

The GPs who acknowledged that early life experiences were pivotal in either supporting or compromising a young person's emotional well-being also took into account the impact of situational influences and offered this as their starting point for understanding emotional distress. The juxtaposition of seminal life events, which frequently occur in adolescence and often compound each other, was also a key finding and is summarized below:

I suppose things change a lot at that age don't they? Maybe they're having exams and things; you don't know if a lot of is the split up with boyfriend, exams, ...friends... so you don't know. It's, not that feeling low due to something like that doesn't matter,

143

because of course it does matter, but you know after all this,

*when the exams are over, things will feel better. (*11; F; 30-39;S)

The conflation of everyday events in a young persons' life, which can result in triggering emotional distress to then unfold upon a particular social landscape, was the framework for these GPs' work.

..It's the borderline between 'are they a little bit depressed' or 'are they quite normal but just having a bad day or two for quite justifiable reasons' that I find difficult to tease out. ..... The commonest situations that young people will come to me with is in the land of unhappiness borderline depression; not coping with some changes that are going on with their life whether it's relationship, school, work. (06; M; 40-49; P)

The ten GPs operating within a biographical- biological paradigm demonstrated a much richer awareness of the complexity of many young people's lives, as manifest in the quotation below, in comparison to those GPs rooted in a Biomedical perspective.

*...it can be quite a minefield and a very complicated question these days because it's rarely mum and dad and baby brother sort of thing. And sometimes that then opens up all sorts of things ... sometimes you have got prior knowledge because you already know part of the family but not always; and some of these young people do have incredibly complicated lives and relationships within the family. (*03; F; 50-59;P)

More generally, psychological distress was attributed to any number of life events which had happened earlier and left their legacy, as indicated below by a GP who consistently demonstrated a broader understanding of the wider context of patient's lives. Her observations indicate a sense of professional frustration at the limited 'treatment options' available but also a responsibility to respond.

....and that with behavioural problems sometimes it's low self esteem and depression, stress that's gone on, sometimes it's

144

previous abuse or something, you know, that's gone on in the past or some bereavement or loss that they are coping with in this way. So I think sometimes it's difficult to try and break that down and so often I find you are referring those on without really knowing quite what's causing it, but you've got the end result of the behavioural problem that nobody is coping with. (05; F; 20-29;S).

Although the view that early life experiences and significant life events had an enduring influence upon a young person's emotional well-being, an alternative view was also represented in the data. This view saw young people as able to 'move on' and recover completely from 'one-off'' life events, with unplanned teenage pregnancy being a cited example.

.... you will have the groups of people whereby they have a short term and very real, maybe a year or 18 months depression often driven by social events, and they may then go on to have a completely and utterly happy life. You know, that they occasionally refer to when you do an insurance form, "I was on antidepressants when I was 17 but I've never needed them since. (14; M; 40-49;P).

Environmental factors

The GPs operating within the biological-biographical perspective were the most likely to display an awareness of the impact of socio-economic disadvantage and its close interplay with mental health.

...I think particularly working in such a deprived area, a lot of the mental health problems around here are as a result of poverty, you know poor housing and ...their routine is awful. They don't know how to cook for themselves, nobody exercises except in bodybuilding injecting steroids, their families don't know how to cope and they are horrible to each other, they say horrible things ; and there is no support ,you know, and there's the issue of drugs. (05; F; 20-29;S)

The complex relationship between income and education conflating into social class was less easily developed in the interviews and the views shared

represented a range of opinion. On the one hand, a GP who worked in a pre-dominantly high income practice area expressed the idea that lower income families demanded less and tolerated their misfortune with stoicism:

> *There is a much more of a sense of sort of dealing with that, I suppose, much more of a sense of just dealing with the problems there and putting up and trying to deal with them in their own way rather than bringing them here. (*09; M; 50-59;P)

This was endorsed by a view that saw disadvantaged families as 'hard to reach' and marginal:

> *There are families I know in Market Town who are not well off, who aren't well educated, they work on fairly well, the parents aren't very bright and I question how much support I could give a distressed child in those families, beyond the sort of basic support... and those kids don't come to us, they certainly don't come independently and they are not brought by their parents.....I suppose there are a lot of kids who are distressed out there who wouldn't see us as being their first port of call. The more, in some ways the more distressed a child is and the less able the parents, the more intensive the support you're going need for it to be any good. Which is exactly what we don't really have. (*07; M; 40-49;P)

The GP here worked in a mixed income market town and considered that it made more sense for GPs, speaking for himself, to marshall their efforts where they could achieve a greater impact than to work with families where the need was greater but with whom they were less likely to effect change.

Others accepted that often in clinical practice it is those who most need care who least demand it:

> *But obviously I think there are factors that come into play that will cause mental health problems that are much more likely to happen in the lower socioeconomic groups... actually I feel as though there should be more of it in those classes and I am not*

146

seeing it so perhaps I am just reflecting on what I've seen rather than what actually is there. (08; F; 30-39;S)

A small number of the GPs did link poverty to mental ill-health but also challenged this by suggesting that in disadvantaged communities there is a stronger social support system. One GP repeatedly referred to the openness she observed within lower income families, and the level of candour with which sensitive topics such as sexual activity and experimentation with alcohol and drugs were discussed

> *I think there is a lot more family support and a better relationship between parents, extended families and children. I feel it's a lot more open environment. So, to be honest, since I've worked here, I've never had any issue starting the 15 or 16 year old girl on the pill, or referring for sort of mental health reasons because they've always been brought in with the mother, and sort of everything is very, very open, and even sort of concealed pregnancies we've always worked it out. (*13; F; 30-39;S)

This position was further developed by another GP working in a similar North Eastern socio-economically deprived community who spoke of the social cohesion as a powerful enabler:

> *I tell you the good thing about Seaside Town, is that it does, and I don't know if you can actually link this to socioeconomic status, but people are, it's a very close knit community, very ,very. Everybody knows everybody's business and families are often massive, extended family network in the area which I think is helpful for children,... if there are problems with mum there is always nana, aunty and.* (11; F; 20-29;P)

Doctors working in more affluent communities brought to the debate a different set of pressures exerted on young people by the adults in their lives which might contribute to poorer mental health through different routes. Below are the words from a GP, practising in a prosperous area with the majority of patients in the high income bracket, who used her own

experiences of mothering pre-teenage children to discuss the phenomenon of parents putting their children under 'performance pressure'

> *Depending on the age of the child, I think I would be quite comfortable and proactive in going there. Parental expectation can be very high and I guess I am speaking as a parent who might have that too... and there maybe all sorts of reason, many emotional reasons why somebody isn't doing as well as might be expected; and it maybe that they are just not that way cut out you know, they are not academically minded or whatever.* (18; F; 40-49;P)

Other GPs referred to the psychological stress young people may experience when their school and family exert high expectations. Below a GP discussed the 'hot-housing' in certain schools which can be destructive to young people's emotional well-bring:

> *You know one of these Academies which has a very particular ethos..... it's amassed itself a considerable reputation as an academic centre so it's quite competitive to get in there and it's undoubtedly pressured in there, and I mean I've met a few.... Probably one of the most recent ones was a guy who was only 12 who had managed about two terms in this school and had to leave which I was quite shocked about. (*10; M; 50-59;P).

Formulations of emotional distress

> *I see more short term distress than psychiatric illness.* (07; M; 40-49;P)

The term 'formulation' comes from the psychiatric lexicon and usually refers to the range of possible diagnoses with reference to underlying causal mechanisms, incorporating a multi-axial approach. Psychiatric formulations are useful in this context to describe the explicit use of constructions which GPs employed to describe how they understood emotional distress in younger patients.

Within this paradigm the dominant construction discussed was the aforementioned 'situational' and 'environmental' factors but two GPs articulated a more psychologically informed model.

> *I would have a trauma based understanding of the depression so I would you know, it'd be rare that I would use anti-depressants, and I would be looking for behavioural responses to the depression, predominantly.... I don't think they've just got a chemical imbalance, so I suppose I am quite locked into a psychological mindedness that the problems arise from life experiences , core beliefs and then there's the CBT type model; ...with a lot of social factors thrown in as well.* (10; M; 40-49;P)

The GP quoted above had a particular interest in working with young people with addiction and in child protection and he spoke of operating within a triangulated frame of domestic violence, substance abuse and mental illness as the backdrop to a significant number of presentations. His articulation of the impact of emotional trauma upon a child's development represented a synthesis of other GPs' more approximate descriptions of the causal explanations for unhappiness in adolescence.

Deliberate self-harm

The ten GPs who clustered together under the biographical-biological perspective' had a different approach to DSH compared to those GPs who saw distress through a biomedical lens. Their dominant narrative which emerged from the data was of 'coping mechanisms'. They saw self-harm as a young person's means of coping with an often almost intolerable burden of pain in the absence of adequate social support and saw their role as promoting alternative ways of coping.

> *it is a reflection of something else that's going on and it's the only way that that child knows to release those emotions and to me it's not suicidal, they are not trying to kill themselves by doing it, you know on the whole but they are expressing themselves and the stresses that are going on. But I see that as very significant because it's a really extreme ....and sometimes it might be 'just an*

149

exam' at school but if that's the way that it's making them feel, if it's that severe and you know bringing those kind of emotions on, you've got to wonder about their coping strategies and pressures they are under and the dynamics they are living within. (05; F; 20-29;S).

GPs who operated in the biographical-biological paradigm appeared to see self-harm as a barometer of internal psychic pain which needed to be responded to with an empathic ear and attention to the social support a young person could access.

*....she doesn't need medication, she doesn't need to keep seeing to doctors in a way, she just needs loads and loads of social support really, and someone to help her through it really because she hasn't got that social network to do it really. (*03; F; 50-59;P)

GPs working from this theoretical position discussed the idea that self-harm was a way of being able to continue in the absence of alternative, less-destructive strategies. Given that the options for improving the social scaffolding of a young person's life may be limited, the GP below, who had worked as a police surgeon for many years argued that it might be safer to not disturb a young person's *modus operandi* where they have declared that they do not want to stop the practice, because of the benefits they perceive.

..... and there are those that do it as a stress relief, because they might not be in control of anything else in their life but they are in control of when they can harm themselves and that whether it's endorphin driven or otherwise it relieves their stress and they feel better for self harming...... how dangerous would it be to necessarily deny somebody of this one power that they have, if they are not going to go on to kill themselves? (14; M; 40-49;P)

The Interpretative paradigm

A third group of GPs sat at the far end of the biomedical model. Their description of practice incorporated the biographical-biological but also extended their repertoire as a clinician to include an exploration of the

patient's narrative. This epistemological position allows for a co-construction of the patient's account, between the patient and GP, with the GP acting as a fellow traveller, accompanying the patient as they come to understand more of their own story. It is based on the premise of a plurality of truths and acknowledges uncertainty and complexity as fundamental to the human condition. Such a position does not disavow a biological reality but rather it works with the notion that reality is mutable and there is no single preferred explanation which discounts all others.

This mode of working was most appositely described by one GP who had worked in the same village practice for over two decades.

> *... and I am becoming more and more a believer in narrative medicine, that none of it actually exists, it's a story and it's an evolving story and I think if that evolving story can have a better ending then it's always a good thing. And I think it's very important how I end it when people leave the room.*

> *Yeah the story is in the past, and it's flavoured with emotions and the only purpose of the story is to be used for the present and the future. So it doesn't really matter that it's 'real', it has to feel real, and it has to be evolving.* (06; M; 40-49;P).

He admitted that this was not a position he shared openly with his peers, and would present "a very abridged version" for his GP Registrars but it remains a guiding principle for him, developed over time and consolidated through reading and teaching medical students and doctors in training.

This approach to practice builds on the biographical-biological position, that is to say, it understands emotional distress as reflecting the earlier life experiences of living in a particular family within a community of specific socio-economic and environmental co-ordinates. Formulations of emotional distress in this paradigm acknowledge the impact of trauma and disrupted attachment and of coping with adversity for young people with a reduced armoury. As practice moves towards a more interpretive perspective there is an increasing intention not to objectify or dehumanise distress. From the

accounts of the GPs represented in this perspective it appears that to understand emotional distress from an interpretive paradigm is to resist the medicalization of distress.

Interpretive medicine overlaps with narrative medicine; both share the same epistemological and ontological roots but narrative based medicine tends to be more focused on influencing a particular approach to patient care and interpretive medicine is a broader church which encompasses a number of complementary and 'appropriate range of knowledges' (Reeve, 2009).

The open codes presented in the table above reveal a number of additional elements buttressing the interpretive paradigm. These are summarized as :

1) It is based in 'relationship care 'which is different to patient centred care'.

2) It is emancipatory in its goal and

3) It is critical of the wider societal factors which compromise emotional health.

Each of these points will be taken in turn below and supported by data to illustrate.

Relationship centred care

An interpretive approach to psychological distress prioritizes the relationship between clinician and patient and invests in building the relationship as a key therapeutic tool. It is a liaison which is built over time and which is dynamic.

> *..and there is a professional judgement moment there, where time alone needs to keep being offered because your relationship with that person is developing and changing over time.* (04; F; 40-49;S)

This same GP introduced the idea of verbal 'contracts'. This was explained as 'contracting with a patient' which is to make a consensual agreement whereby the patient, having disclosed suicidal ideas to their GP, commits to not acting upon the thoughts of self-harm, and agrees to accepting close supervision by the GP involved in their care. This was a practice the

aforementioned GP had been doing for some time and is a specific example of a GP and patient journeying alongside each other as the patient's story unfolds. It demands an ability to work with a degree of uncertainty which could be overwhelming for a less experienced and confident GP, with whom such a practice might not be safe. It is described below

> *......I am going 'to contract with you' around that, that you use that to help you close down those thoughts of intent and you are going to contract with me to stay safe, to not harm yourself in any way until we meet next week....it's sounds a little whacky but part of it is that they know that you care and it's amazing the number of people, including young people, who pin a high value on that relationship and support and they will think... as well as having something to handle it with now.* (04; F; 40-49;S).

A therapeutic relationship which can achieve this degree of exchange is necessarily built upon an honest sharing of concerns and mediated through a common language which puts young people at their ease, allowing them to share their worries and discuss their personal situation. This is discussed below by a GP with an interest in working with young people with addiction problems. He displays his ability to facilitate conversations in which young people can share stories of neglect and abandonment of hope in ways which surprise other experienced practitioners.

> *You have got to have the rapport you know, you have got to speak the language....It's my experience when I have trained nurse practitioners and practice nurses sit in on my consultations, ... they can't believe they live in the same world ...Even though they work just be a mile away. ....Just the stories of trauma and despair that they hadn't heard. That's quite common*. (10; M; 40-49;P)

The narrative approach of the interpretive paradigm offers hope and builds on the fact that a young person seeking help still has hope for their future. This is a generic stance but might have particular import for young people

who have been reported to feel hopeless and alone in their confusion and distress (Biddle et al., 2006)

Emancipation and patient empowerment

GPs who operated at the far end of the biographical-biological perspective spoke of wanting to work with patients to equip them to find their own potential source of creativity and resilience. This was a minority position and was often discussed more when the participant GPs referred to their experience of working with adult patients

> *My abiding sort of aim is that dealt with early, and with every consultation. it does give us an opportunity to support people in managing that emotional distress, you know, that drop in emotional resilience - you are building in something that produces a more long term approach to emotional resilience in that individual.* (04; F; 40-49;S)

Taking an emancipatory view removes the responsibility from the doctor of 'solving the patient's' problems or 'rescuing' them, which can be liberating for the practitioner.

A social critique

A Habermasian framework (Carr, 1986) connects an emancipatory position with a reflective practitioner and also one who is critical of the context in which the clinical encounter evolves. This critique of the socio-political fabric of patients' lives is not always present in the biographical-biological perspective and practitioners operating in the interpretive paradigm will vary in their awareness of the wider context of patients' problems. Below is an extract from a GP working interpretively who attributed assaults to young people's emotional wellbeing as coming from the negative pressures which society applies to their lives:

> *We cannot all be emotionally well all the time, it's what we do with the emotional distress that counts and it's what facilities we have around us in supporting us to deal with that. A huge issue in this area is self resolution of emotional distress, ...I think that we place*

our young people, as a society, in the most intolerable situation
that we could possible design for a human being and that if they
don't hit 'depression' they are blinking marvellous. (04; F; 40-
49;S).

Deliberate Self-Harm

The four GPs whose stance most correlated with practising interpretive medicine did not signal out acts of self-harm in the same way as GPs operating within the other two paradigms. For this group, self-inflicted pain was yet another expression of young people's psychosocial adjustment difficulties. It might be seen rather as a response appropriate at that time and within the repertoire of anybody who feels under stress; rather than seen as an incomprehensible act done by 'others'. The GP quoted below appears to 'normalize' self harm but nevertheless remains unsure about how best to respond.

> *... but I think we've all done it in some way, whether we've bitten*
> *our lip when we've banged our toe.. it's a way of releasing emotion*
> *in a controlled manner .... surely that is the most acceptable end*
> *of self harm. So accepting that we all do it to some extent, I have*
> *some comfort with it. It can be classed as something that ranges*
> *from normal behaviour through to significant psychological*
> *distress. I guess my problem with self harm is deciding when I'm*
> *going to do something about it. (*06; M; 40-49;P).

The findings presented as the axial codes in this chapter inform the subsequent and final stage of analysis which leads to the selective code and the conceptual framework for the emergent theory and will be presented in the following chapter.

Chapter Five: The Enactment of Role

Introduction

This chapter will present the final stage of the analysis and complete the building of a conceptual framework, based on the empirical data, in order to better understand GPs' response to emotional distress in young people.

Having articulated the three pillars of the framework the next stage was to determine the selective code which aims to represent all of the data. By providing an over-arching construct the selective code endeavours to explain how the axial codes intersect and interact and ultimately defines the conceptual model which explains the findings.

The three axial codes articulate the three domains which exert their influence upon a GP's response to an emotionally distressed young patient. The GP's performance in the clinical encounter, their perspectives of young people and their understanding of their health needs, underpinned by their preferred epistemological frame of reference will shape the GP's response. It is at the intersection of each of the axial codes that a GP's readiness to engage with young people is determined.

Analysis of the data suggested that the unifying theoretical construct which explains both how and why certain GPs engage with young people or not, is the perception and the enactment of their *role* as a GP when facing young people with emotional distress.

The constellation of the three positions a GP holds will shape the enactment of role in the consulting room, and also beyond, in terms of the value they hold in investing in young people's emotional well-being and seeking to deliver this through their practice's organizational system.

The use of the term 'enactment' refers to the public, external display of a practitioner's position on each of the three axes. It is a term which recognizes that the practice of medicine entails an element of performance from the practitioner, and that what happens in the consultation is more than simply what is said.

Roles

The empirical data collected in this study suggested a typology of three role archetypes: the *'Fixer'*; the *'Future Planner'* and the *'Collaborator.'*

These roles have been named using *in-vivo* codes which endeavour to capture something of the vitality of their meaning and each will be described in detail below. Charmaz suggests that using phrases which come directly out of the data, that is, *in-vivo* codes, adds authenticity by being grounded in the social worlds and organizational settings from where they are derived (Charmaz, 2006: 56). Although three role types are described, it is important to state that within each role there is a continuum with GPs at one end of a role type working slightly differently to those at the other end. In this sense the role typologies are themselves on a continuum and there are 'grey areas' at the boundaries of each role type to which will gravitate 'the floaters'. These 'floaters' represent the GPs whose *modus operandi* is in flux and open to change. Based on the empirical data a description of each of the GP role archetypes is presented below.

Fixers

The primary purpose of a *fixer* is to deal solely with what patients bring to the consultation, to identify and label 'the problem' and devise a management plan with the intention of solving 'the problem'. GPs who operate as *fixers* work in 'the here and now' and are much less concerned with planning for the future. Health promotion has very little currency in their role. Presentations of ill-health are viewed simplistically and pragmatically. With regard to the range of problems young people might bring to a GP, the *fixer* tends to see them as typically 'straightforward', as shown below:

> *....(teenage)medical problems can be relatively easily dealt with, always nice to deal with easy problems, so some kind of medical straight forward disease things you know I'm thinking about acne, contraception...no point making it more complex than it is.* (02; M; 50-59;S)

Analysis identified six of the GPs to be working with a *modus operandi* which might be best described as a *fixer*; the characteristics of the group include five male, one female; five aged 40-60; one (male) aged 30 years old. This group of six included the same six GPs who operated in the biomedical sphere and who also saw young people as a separate and 'difficult' group of patients with whom to work. The characteristics of this archetype will be presented below, mapped against the three axial codes.

Fixers' and their performance in the Clinical Encounter

Although the majority of GPs interviewed expressed feelings of anxiety, '*fixers*' seemed to describe a professional detachment which led to a dis-engagement with troubled young people. Other role types also exhibited anxiety but the response to it was different, and will be discussed in the relevant sections.

> *I am quite anxious about mental health problems in young people cos I don't have huge experience.....I probably tend to refer them on early cos I don't know what else to do.* (09; M; 50-59;P)

One way of dealing with multiple and uncertain expectations within a consultation is to limit the range of possibilities and to take control. This is a doctor centred position which puts the locus of control on the doctor and does not seek to gain the patient's perspective. It is illustrated in the words of a GP below:

> *Yeah I think on the whole I like to sort things out, ...if you come in with multiple problems I tend to like to sort them all out, don't know if that's a good thing but that's seem to be how I am. And I quite like to make a definite plan, take a definite action. I think I prescribe quite a bit, I think I probably prescribe a bit more than average.* (17; M; 30-39;S)

Another way *fixer* GPs dealt with anxiety, which can be professionally compromising, was to delimit the areas they were prepared to discuss in the consultation. The 'swampy' presentations of conflict at home, anger outbursts or withdrawing into silence do not sit easily with a 'quick fix'

approach to practice and so framing the problems as 'non-medical' moved the problem out of the GP's zone of 'legitimate' areas of medical concern. Whilst it does not preclude patients from raising such topics the *fixer* GP has determined that young people's emotional well-being is not in their remit.

> *I mean I kind of have reservations about that...there is a limit to how much doctors or GPs can or actually should be involved in sorting out the ills of society.* (02; M; 50-59;S)

Once the boundaries of what it is permissible to discuss are staked out it follows that intimate disclosures are unlikely to happen, thus minimizing uncertainty and unpredictability in the clinical encounter; and with 'cultural clashes' far less likely to arise. The *fixer* sees the consultation as an opportunity to exercise control and 'sort out' what a patient brings to the table, not explore what lies beneath it.

> *GPs are problem solvers you know, getting to grips with the issue which is there. I mean, I think GPs are very good at dealing with what's placed in front of them as a problem. (*07; M; 40-49;P)

> *GPs aren't looking for more to do, I mean they just aren't, it's quite extraordinary really the level at which general practice is pitched at now I think.* (09; M; 50-59;P)

Fixers' perspectives on young people and their health needs

Young people were seen as problematic in their health seeking behaviour. They were viewed as being difficult to communicate with, unreliable in their 'follow-up' behaviour and likely to make decisions which might adversely affect their health. Below are two statements from two GPs working in the *fixer* mode.

> *I think they are a difficult group, partly because of the sort of way I suppose things present and the way they access us and the way they relate to the problems, that can be difficult. And all the issues about confidentiality and parents being present or not present comes into it. (*09; M; 40-49; P)

....maybe they don't know how to act at the doctor's; they don't know how to engage, they don't know the format of the consultation and the barriers to maybe coming back, you know, when will they come back? do they know how to make an appointment etc? (11; F; 20-29;S.)

Viewing young people negatively tends towards a less hopeful position with regard to what a consultation might offer. There was also however an ambiguity, even amongst those operating as *fixers* about how much agency young people had to affect change in their lives, which one or two in the group recognized. One GP discussed the relatively undemanding nature of young people in the surgery:

..so, there is something with youngsters - actually they don't necessarily demand a lot of time whereas with an adult you can really find that they are kind of controlling the pace of the consultation. (07; M; 40-49;P)

For the *fixers* this was an advantage:

..you have more control....you finish the consultation if you want to. (07; M; 40-49;P)

However this GP recognized that young people's low demand was probably secondary to lacking the ability or confidence to be bolder in their demands, and meant that more important issues were often not raised if the GP did not take the lead; as he suggests below:

I think, there is an issue about young people particularly that they may not be very assertive in pushing that so you often do the easy thing and then the more difficult thing gets left because there isn't that sort of assertiveness. (07; M; 40-49;P)

GPs working as *fixers* might not necessarily be comfortable with this *modus operandi,* but feel unable to perform differently. During the research interview this same GP seemed uncomfortable yet spoke with candour in declaring his consultations to be 'skin deep'

My consultations can be quite superficial as well, you are conscious that you don't always get under the skin and find out what the problem is. (07; M; 40-49;P)

Fixers' epistemological frames of reference

Fixers operate within the positivist ,biomedical paradigm and draw upon factual theoretical knowledge. Using an Aristotlean frame of reference this approach would be referred to as *techne* (Aristotle, 1973, cited in Carr,1986: 183). Such tools are rooted in a nomothetic view of the world which assumes universal, generalizable truths, matched with an assumed objectivity on the part of the clinician. It is also a position which prioritizes biomedical knowledge above all other sources of knowledge and it foregrounds 'the doctor' as the principle actor.

Such a perspective leads to seeing the young person's story as 'insubstantial' and which cannot easily be 'corroborated'.

*There are those issues of trying to calibrate and diagnose young people. It's not like somebody comes in with asthma where I can peak flow meter out or border line diabetes and send them for fasting blood sugar. I don't have the out and out objective tests. (*06; M; 40-49;P)

By prioritizing the biomedical paradigm other frames of reference are marginalized. The consequence of this is to disregard other disciplinary perspectives. This was translated into a dismissive attitude towards the work of CAMHS teams expressed by some, but not all, of the GPs operating as *fixers*. This could be moderated by local relationships between the GPs and their CAMHS teams. GPs who worked as *fixers* but who had good personal links with their secondary care colleagues valued the input from CAMHS and different disciplinary approaches to formulating problems.

It's enough for me to decide somebody needs some specialist input and what I do every time is: I ring a clinical psychologist at X, I explain to her where I am, and I say what do we do (in general practice); she says leave it with me and she directs them either to

emotional wellbeing or child and family or CAMHS or whatever. (09; M; 50-59;P)

Future Planners

The second role archetype supported by the data was the *future planner*, an *in-vivo* term taken from an interview transcript:

> *...rather than a quick in and out I think I am more of a planner for the future rather than a fire fighter type person.* (16; F; 20-29;S)

Seven of the participating GPs fitted with the *future planner* model. Six were female, aged between 29 and early 50s; one was male in his late 40s.

This role type also liked to work with 'problems' but had a broader vision than the immediate presentation, or one of solely focusing on 'problems' which could be easily solved with a prescription. GPs working as *future planners* liked to extend their gaze further ahead by aiming to equip patients to self-manage and take greater responsibility for their health. It was a *modus operandi* which started with the patient's agenda but which allowed the doctor to develop their plan by introducing doctor-centred tasks

> *...you know you haven't sent them out the door with their prescription in the first two minutes, so you've got the other 8 minutes to find out things they are going to tell you about so I am sure that will kind of help with that and the fact, I do like to chase numbers, you know "the perfectionist", so I do like to follow up the chronic things and try and see improvements and you know I want to know if things are better or if they are worse.* (16; F; 20-29;S).

This extract indicates the future perspective which is central to this role archetype and which differentiates it from the f*ixer* role which works much more in the present.

Future Planners' and the Performance in the Clinical Encounter

The GPs who populated this group approached the demands of the triadic consult with a pragmatism which appeared to moderate their levels of anxiety and professional uncertainty. For the four younger GPs who clustered together in this role construct, their undergraduate medical education which included 'communication skills learning', seemed to have equipped them with a structure with which to better address the demands of the triadic consult. They also used tools, such as 'focused questioning', which GPs of an older generation did not refer to.

> *I mean I think you start off with a general, quite broad approach, and then maybe hone in towards the end....I think you have to be quite flexible so if there is something you need to know I will be much more direct.* (16 ; F; 20-29;S)

The balance between a flexible and a direct approach needed to be framed within natural language and with the GP appearing 'relaxed', as shown below

> *I am quite open and quite happy to ask any questions. I think it's being quite laid back about it and trying to find out if they know why they are here; and most of them do, and they know what the issues are. I generally find that they do give a good story and history and at the end of it a lot of them are happy for further help or to talk to somebody else. (*13; F; 30-39;S)

What emerged from the future planners accounts was that less anxiety encouraged greater curiosity. It also allowed the young person the opportunity to talk on something about which only they were the expert - their own life

> *I think I they are kind of almost quite enjoyable consultations because it's finding out a bit more about them, about the set up at home, how are they getting on at school, what they enjoy doing.* (16; F; 20-29;S).

For the three older GPs their approach seemed to be shaped more by using professional and personal experience combined with reflection than by more formal education. Examples of experiential wisdom which GPs who worked as f*uture planners* drew upon included considering what had worked in the past to resolve conflict, putting the young person centre stage and allocating more time to these complex consultations, as discussed below:

> *I think it's trying to focus on the young person really, sort of at the centre, and not letting, cos sometimes you find parents trying to take over the whole consultation. There are times you have what looks like stand up arguments with them disagreeing with sort of various things, so I think, you know, turning your attention to the young person and in those, often as I say trying to separate them if necessary and talk to them on an individual basis I think... just have to take your time, bring them back at another time where you've got more time available. And you can't do it in sort of 10 minutes basically.* (18; F; 40-49;P)

Future Planners' perspectives on young people and their health needs

This group of GPs demonstrated a greater awareness of the multiple demands upon a teenager during adolescence when compared to the *fixers*. Their awareness of the challenges arising during the transition period led to a sense of compassion and a sensibility to the demands, recognizing that young people often needed time to be listened to. The late teenage years were described as a "more vulnerable time" in terms of increased demands:

> *I think it's a very emotional time, obviously a very stressful time whether they are still at school, college, relationships, both sexual and with their families and parents. I think there is potential for so much to be going on and obviously sort of people dabbling with drugs and alcohol I think it's erm, it is harder to deal with.* (13; F; 30-39;S).

An older male GP felt that the over simplification of 'teenage troubles' was unhelpful and resulted in 'knee-jerk ' responses which promoted a biomedical response to adolescent emotional distress

I think that there are a lot of people who perhaps fail to recognise that a teenager's lot is a tumultuous lot, there are highs and lows of everything and sometimes we are too quick to label and too quick to want to refer and too quick to want to prescribe something which is actually part of the normal experience'. (14; M; 40-49;P.)

This ability to see young people as facing a number of challenges led to a view that young people were a special group who needed a response which was sensitive and cognizant of their needs; rather than seeing them as a group who were inherently 'different and difficult'.

A theme which ran through the interviews with the *future planner* GPs was the important role a GP might play in preparing young people to better deal with their future health through giving young people more information about their health needs and promoting empowerment. Reducing doctor dependency was seen by a number as being a key function of the GP. These features are illustrated by two GPs, working in different but similarly disadvantaged communities.

*....And I think in adolescence it's picking up on big problems ,so is it their weight that you want to tackle? is it how they cope with stresses and thing?, trying to sometimes empower them about, oh what you doing at school? - what are your plans for the future? (*05; F; 20-29;S)

Both of these GPs promoted working with young people as important but were very alert to the risks of creating 'doctor dependency'. This resulted in a pragmatic approach to the construction of their relationships with patients, or what the GP below describes as a 'new culture'.

It's important that we talk about all these important things - you've got to look after yourself ....we are just here to guide you and offer you advice and it's nice at that early age to give them that kind of impression so that they don't come in and go "here are all my problems, you deal with them", which is what a lot of adults do and I think it's been something that's been learnt over

> *a long period of time and maybe that's what GPs used to do years and years ago and trying to get that new culture of "no, they are your problems and we are here to guide you but you are ultimately responsible for what happens.* (05; F; 20-29;F)

Although this position accorded young people a considerable degree of agency and assumed a degree of trust on the part of the young person it nevertheless appears as a largely 'doctor led' approach.

Future Planners' epistemological frames of reference

Future planners work in the biographical-biological paradigm and so, in contrast to the f*ixers*, take into account the context of the patient's life. However, all doctors practise along a spectrum and will vary in the degree to which they broaden their discussion into what constitutes a 'medical' from a 'social' history. The young doctor quoted below is unequivocal in her confrontation of the social reality of many patient's lives, albeit seen through the lens of her own experience.

> *....it's often not the medical side of it that needs sorting out first it's often other things which can help them and if you're only looking purely from a medical side of it - it's going to be a huge group of people that you're never going to be able to help.* (05; F; 20-29;S)

The influence of the family was seen as central and could work both ways. Illustrations presented earlier show how families which were open with each other and encouraged discussion of sex, drugs and alcohol could render the GP's task in the triadic consultation easier. On the other hand, GPs working within a similar paradigm talked about families which were a source of distress. Once acknowledged, the family matrix with its relative strengths and weaknesses, needs to be incorporated into the GP's 'game plan' if the plan is to be relevant and meaningful for the young person.

The GP working as a *future planner* is likely to take into account the young person's situational and environmental factors, their earlier life history in terms of key events and to use this knowledge to produce a formulation

which looks at the young person's behaviour and emotional state in the context of these factors.

Collaborators

The third and final role type seen from the empirical data was the *collaborator,* first introduced in the extract below*.*

> *...it's a very collaborative sort of approach where we find out what needs doing and then we divide it up between us.* (04; F; 40-49;S)

This archetype describes a GP who sees the consultation with an emotionally distressed young person as an opportunity to collaboratively work out what 'the problem' might be, as it is understood by the patient. Together the story is then co-constructed in a way that is meaningful, at the same time as developing a trusting relationship based on a mutually respectful regard. The GP does not set out to 'solve the problem'.

The aim of such an approach is to empower the patient within their own environment, cognizant of its particular features. The family context is recognized in a way seen in the f*uture planner* role but a more questioning and critical stance is adopted, as will be discussed below.

Three GPs were considered to be *collaborators* in their *modus operandi.* All were in their late 40s and comprised one woman, two men. Two had specialist roles in offering local leadership in mental health and child protection, one was a GP Trainer. Two worked in areas of high deprivation, one in a rural predominantly affluent village. GPs who were assigned to the 'floater' category, moved in and out of the *collaborator* mode.

Collaborators' and their performance in the Clinical Encounter

Two of the GPs in this group expressed no degree of discomfort in dealing with consultations concerning young people's mental health, the triadic consult and competing demands in a consultation, but one did admit to feelings of self-doubt about what he was able 'to do'. The key difference with this approach was that *collaborator* GPs used the anxiety as a trigger for self-reflection and as a tool to look at what was making them uneasy in the

consultation. The GP below, working with more affluent families shared multiple examples of problematic case vignettes where he was unsure of what to do but remained tenacious and committed to working with the young person until they ceased consulting.

Another way in which GPs working as *collaborators* dealt with anxiety in the clinical encounter was to look at the situation from the young person's position and understand that not only would they be feeling disempowered and anxious by the situation, but that it was the GP's responsibility to moderate the anxiety.

> *....there is often a lot more angst around it, some of that I think is sometimes lack of knowledge, not necessarily of the condition but of what are they going to face coming into that service, what are they going to face if they are going on to the next service, and what I tend to do is be very clear about why they've come, what their concerns are, what my role is, what a parental role might be. (*04; F 40-49;S).

Because c*ollaborators* accept the inherent uncertainty they are much less disorientated by 'the unexpected' arising in the consultation or by a 'cultural clash' occurring. At the same time, since they are involved in co-constructing the story, fewer 'surprises' emerge. Below, one of the GPs describes his mode of working which is to always consider the family matrix; its social history and biology and to resist focusing on the behaviour of the young person as the starting point. Once the bigger picture is taken into account, then the outward manifestations of distress take on a different meaning.

> *I would never think of the young person in isolation. I will always think of the family. I am always looking at always picking up domestic violence, mental health, substance misuse, they always go together and I just cannot imagine a young person in distress where that's not around.* (10; M; 40-49;P)

Collaborators' perspectives on Young People and their health needs

Whilst the prevailing view was of young people as being on a life-journey and not as a distinct and separate social sub-group there was a recognition that socio-cultural factors exert a powerful influence on young people and need to be taken into account. Recognizing and including the wider context of young peoples' lives would also promote trust in the clinical encounter. The GPs' accounts suggested this was less about resisting the idea of young people as 'a different species' but more about valuing a culturally appropriate response which acknowledged their particular transitional phase, without making assumptions.

GPs operating in a collaborative mode sought to establish 'a therapeutic alliance' with the young person. This might not always be a comfortable process and often involved 'awkward silences' but it demonstrated the commitment of the GP to working with the young people until either the situation was resolved or another professional stepped in, as revealed by the vignettes shown below:

> ....a*nd he still comes to see me but I think maybe just at this moment in time I'm the least frustrating professional he is dealing with. I still don't think I'm doing very well with it, because I know that I don't feel happy with it; but I don't know anything else to do with it. Cos I don't have anywhere easy to refer him to because he has been to all of the different services and I don't feel I can tell him to stop coming because he wants to move back into the family home.* (06; M; 40-49;M)

The GPs who adopted this *modus operandi* stressed the importance of building trust and saw the relationship evolving over time. They recognized that it was not feasible to expect young people to expose their vulnerabilities, either without a trusted member of the family, or without the scaffolding of a therapeutic relationship.

Collaborators' epistemological frames of reference

The epistemological framework for this mode of working is the interpretive paradigm. This relationship-centred model of care sees the doctor-patient relationship as therapeutic in and of itself and uses it to explore what is important for the patient, seeking to work with them in addressing those expressed difficulties or goals. This style of working inevitably embraces health promotion as part of the consultation as the doctor employs a holistic approach. In order for such a therapeutic relationship to be effective it has to respect the context in which the patient's life is lived.

The c*ollaborator* seeks to emancipate the patient through empowerment and to this end draws upon a different armoury. The doctor will use both formal cognitive knowledge but also *phroneis* (practical wisdom), which endeavours to combine knowledge gained from the external world (*sophistry)*, with *phroneis*, to effect change. This is a model which recognizes that medical knowledge is interpreted and gained through oral culture, apprenticeship and the use of the case method. Nor is it a system which precludes the use of propositional knowledge in the form of guidelines and protocols, should they be of use in the clinical encounter in question. Working in the interpretive paradigm as a c*ollaborator* does not translate to a prescriptive mode of working but rather opens up the plurality of ways in which different forms of knowledge can be used to work with the young person to reach a greater understanding.

With regard to time frames, where the f*ixer* remains fixed in the present, and the f*uture planner* has their eye on the horizon ahead, the c*ollaborator* works with the patient and their narrative to incorporate threads from the past, present and future.

As was discussed earlier in the section on the interpretive paradigm, GPs who work within this framework respect the disciplinary perspectives of colleagues working in other specialities; such professional disciplines might include school nursing, clinical psychology and youth work. GPs operating as *collaborators* work with their colleagues to promote change with the young people, and where possible their family.

> *...the emotional wellbeing team pick up a lot of the low grade*
> *problems and there is the school nursing service of course. I might*
> *speak to them, and find out what's happening because you know*
> *they may be seeing the behavioural support service in the*
> *school... So that's part of the jigsaw trying to build the picture*
> *up.....the culture and the area seems to be one with appropriate*
> *information sharing and child centred. And similarly with social*
> *services, I think on the whole they are reasonably good.* (10; M;
> 40-49;P)

The final area of distinctive practice of *collaborators* was the awareness of
other social and contextual factors impacting on a young person's emotional
health and well-being. GPs in this role type talked about considering the
wider societal influences:

> *In terms of the culture, right, where do we place, as a society, value*
> *on young people? academic achievement, not wrecking the place,*
> *not taking drugs, where is the positive value of that young person*
> *and what they contribute to society? You know, so we are in a*
> *sense, as a society, isolating that group as something not as a*
> *valuable, adolescence is 'something we have to go through'.., but*
> *the ideas the innovation, the logic ,of young people is phenomenal .*
> *'*(04; F; 40-49;S)

Undertaking a critical analysis of the complexity of young people's lives,
showing an awareness of the plurality of influences which they must
negotiate and adopting a discerning position on contemporary social life are
important features of working as a *collaborative* GP.

'The Grey Areas'
This concluding section refers to those border areas which sit at the margin
of categories. Three GPs did not sit easily within the core categories and
several more could move between two role types. One GP (11; F; 20-29;S)
showed aspects of both the f*ixer* and the f*uture planner* and so sat in the
liminal area between the two. One older female GP sat between the f*uture
planner* and c*ollaborator* role and by her own admission talked about moving

between roles, according to external pressures and internal factors. When the role types were presented to her in the interview she responded,

I would say that I have bits of lots of those. (18; F; 40-49;P)

And personal preference is moderated by external factors, as the same GP indicates below:

I think that exploring things is lovely but I don't think there is an awful lot of time in general practice and so I think that can constrain things...and its important to be aware of my limitations....we are generalists. (18; F; 40-49;P)

Even those GPs who appeared to exhibit core features of the role archetypes demonstrated behaviours which exploited strategies from the three types and might well have presented case vignettes which illustrated them acting 'outside of role'. The GPs identified as exemplifying 'classical archetypal role behaviour' may also contend their categorization. For example both of the male GPs who most closely fitted the *collaborator* model both contested that they worked therapeutically, and yet they consistently described examples of practice which demonstrated a desire to develop the patient's narrative, over time, through developing a trusting relationship with the young person and exploring options to lead to a more positive emotional state. The doubt they expressed seemed to originate in a question about how legitimate it was to spend time in this sort of clinical work.

The GP who worked with young people with a history of serious drug abuse also had to be pragmatic in his approach as there were multiple practical issues which needed resolving before therapeutic work could begin, such as organizing housing and income.

In this little cohort it's about stabilising them. Getting the methadone script, then getting housing sorted and maybe employment, or benefits and really it takes a long time to build up their formulation for them so they can work it out and understand. (10; M; 40-49;P)

As a result of the prolonged contact he had with the small group of young people, described as

> a discrete group of very damaged young people caught in prostitution, crime, being abused, using heroin, class A drug...they are a small , significant minority. (10; M; 40-49;P)

he developed close relationships which led to knowing this group '*extremely well*' and as a result working therapeutically, in parallel with a '*raft of other people*'. However, he did not feel he translated this work into working with other young people who exhibited emotional distress without a substance misuse base. In these instances he considered his main role was in

> supporting the family and validating the young person's distress. (10; M; 40-49;P)

Hence, the value of discussing role types as fixed categories and of suggesting how the data mapped to the types, is to offer a conceptual model which allows a description of possibilities. It serves as a framework for exploring how GPs respond to emotional distress in young people and offers a route map for GPs who want to change their pattern and degree of engagement with young people.

The framework is presented below in diagrammatic form to demonstrate its purpose as a route map and to indicate the specific areas where a GP's position has been shown, by the data, to shape their degree of engagement with emotionally distressed young people.

A Conceptual Framework: the Enactment of Role

Archetypal Role Types Axial Codes	FIXERS	FUTURE PLANNERS	COLLABORATORS
The clinical encounter The triadic consult Dealing with the unexpected Cultural clashes	Anxiety provoking Challenging Psychosocial problems deemed non-medical Terrain kept 'safe'	Sets aside, restrains emotional response Compassion grows out of long standing relationships Some context important	Awkward feelings acknowledged Compassion important Critical of the social context
Perspectives on young people Life cycle or 'other' Developmental trajectory Trust Duty of Care Agency	- Seen as 'other' - Adolescence a 'phase' to be passed through - GPs responsibility is to fix problems - young people possess agency	young people are on a continuum Health Promotion in this group is important – developing emotional resilience A duty of care is important Mixed position on agency	young people are individuals, on a journey GP Role is to empower patients + to promote their creative capacity The therapeutic relationship is central- builds on trust Agency is moderated by external factors
Knowledge Frameworks Paradigms Tools Power Working with colleagues	**Biomedical** Technical Dr centred Dr Centred model Prioritizes biomedical knowledge	**Biographical-biological** Praxis Dr controlled, Patient centred Accesses other Professional staff Accepts other frames of reference	Interpretive Phronesis Relationship-centred Power is shared Promotes respectful collaborative working with patients, family, colleagues

Chapter Six: Defining the role of GPs in responding to emotional distress in young people

Introduction

This discussion chapter will summarize the principal findings of this study; it will compare and contrast the findings reported here with what is already known about the subject from the literature and it will critique the relative strengths and weaknesses of the study design. The chapter will lead into the final chapter of the thesis which discusses the study's implications for practice and make a series of recommendations.

Summary of study findings

This thesis presents an exploratory study conducted in a relatively under-investigated area of clinical significance. If emotional distress is not identified in young people relatively early in its presentation, longitudinal studies confirm that it can be recurring, if not enduring, with multiple ramifications in adult life (Kessler et al., 2005, Goodyer et al., 2003, Gledhill and Garralda, 2011).

The data generated in this study demonstrated that GPs vary in their response and degree of engagement with young people who present in primary care with emotional distress. Using grounded theory, enriched by undertaking a situational analysis, a conceptual model has been developed.

The three pillars of the model are a GP's performance in the clinical encounter; their perspectives on young people and their health needs and a GP's preferred epistemological frame of reference. Each of these axes articulates with each other, and the conflation of a GP's position on each of these axes translates into the enactment of their role. The performance of their role will be influenced by the contextual circumstances of the individual clinical encounter.

The data led to the development of three role archetypes which mapped to the three pillars (axes) of the conceptual model. These have been described, using *in-vivo* codes, as *fixers, future planners* and *collaborators. Fixers* focus on the here and now and adopt a problem solving approach which is

dominated by a 'doctor driven' agenda. They respond to professional anxiety by narrowing the field of legitimate concerns to be addressed in the consultation. In general, this archetype viewed young people as 'different', often 'difficult' and requiring particular communication skills with which to consult effectively. They also saw young people as autonomous individuals, able to ask for help if needed.

Future Planners represent an archetype more cognizant of the value of developing a relationship with the individual young person but remain guided by a 'doctor led' agenda. More mindful of the context of the young person's life they are willing to suggest brief behavioural interventions and advocate a health promotional element which looks to the future. They recognize that young people are not always in a position to take responsibility for their own health needs but do not prioritize a pastoral relationship (Cocksedge and May, 2005).

The final archetype to be described is the *collaborator* who adopts a relationship-centred approach and prioritizes 'the therapeutic alliance' (Heyland, 2012). GPs who adopt this *modus operandi* accept the uncertainty inherent in an evolving story associated with emotional distress and work with the young person to co-construct their story whilst remaining mindful of the safety of the young patient. They value a plurality of knowledge frameworks which permits them to respect and work with other health and social care practitioners.

Fifteen of the 19 GPs were matched to the archetypes whilst four appeared to adopt a more flexible approach and were identified as *floaters,* able to move between role types and were not committed to a dominant way of working.

The development of this model placed in centre-stage the function of the GP's role in terms of determining the degree of engagement a GP may display when faced with a young emotionally distressed person.

In centring the concept of role, through the exposition of the conceptual model, the contrasting void in which the expectations of a GP's role in

managing adolescent emotional distress are understood, is highlighted. Currently there is *no* clearly defined role for the GP in adolescent primary care mental health.

This position contrasts with a range of common conditions which are seen in general practice, such as the management of hypertension, asthma and diabetes where the expectations of a GP's role are made explicit, are measurable and rewarded. In contrast no parallels are observed when a GP responds to a young person in emotional distress. To do so is to enter into a clinical arena which is not bounded by a professional and peer consensus of what constitutes 'legitimacy' in this area of practice.

How do the study findings compare to the existing literature?

The structural and policy context

Every Child Matters (Department for Education and Skills, 2002) was a landmark document which captured the government's commitment to improving the emotional well-being of children and young people around five axes: to be healthy (both physically and mentally); to stay safe (be protected from harm and neglect); to enjoy and achieve to their capacity; make a positive contribution and experience good economic well-being. With the passing of the Children's Act in 2004 the framework described in *Every Child Matters* had a legislative structure.

The 'blue print ' embedded in *Every Child Matters* (2002) and developed in the succeeding National Service Framework, sought to clarify the role of 'front line' practitioners. As part of *Every Child Matters* a common assessment framework (known as 'the CAF') was developed 'for use by all practitioners working with children' (BMA, 2006). This offers a nationally standardized approach to assessing the needs of a child with the aim of early intervention to prevent problems (idem. 2006: 21). The BMA report declares that all Local Authorities were to have implemented the common assessment framework by 2008. From the data gathered here only three GPs were familiar with the term 'CAF' and none had conducted the process.

The *National Service Framework* (NSF) for children, young people and maternity services (Department of Health, 2004a) built upon the groundwork of *Every Child Matters* and included 'standard 9' which specifically referred to the mental and psychological wellbeing of children and young people. The NSF highlighted the role of primary care professionals to identify those at risk of developing mental health problems and made recommendations; but it could not enforce a cultural change in how GPs view their role in managing adolescent emotional distress. The government's rhetorical commitment has continued with subsequent documents such as *Early Intervention: Securing good outcomes for all children and young people (*Department of Health*, 2010b). However, without a corresponding structural change in primary care and, given the impact of performance related pay becoming integral in the culture of contemporary general practice (McDonald et al., 2007b, Checkland et al., 2008) policy documents alone cannot shape practice.

Other important policy documents have identified the conflicting tensions in understanding the GP's role when managing the emotional wellbeing of (children) and young people, notably evident in the Kennedy report (Kennedy, 2010). This document viewed younger patients as being poorly served by the NHS. The report described a GP workforce which currently has no mandatory requirement to have undertaken post graduate training in paediatrics in order to achieve independent GP practitioner status. The RCGP Child Health Strategy recognizes this anomaly and as part of a wider brief advocates extending GP training to five years which would increase exposure to children and young people (without making Paediatric training mandatory) (Royal College of General Practitioners, 2010).

Data from the study reported here showed that GPs who had enjoyed a positive paediatric attachment as a student and/or as a GP 'in training' felt more confident in talking to young people in general, recalling examples of good practice to which they had been exposed.

The advent of NICE, now responsible for developing the quality indicators for the QOF, has produced a modest number of guidelines addressing mental health in under 18 year olds but by its Director's own admission has not

focussed on this population (Rawlinson, 2011). The only NICE guideline referred to by participants in the study was the work on Depression (National Institute for Health & Clinical Excellence, 2005). The most recent and relevant to this cognate area might include the guideline on Attention Deficit and Hyperactive Disorder 2008 (National Institute for Health & Clinical Excellence, 2008) (given the co-morbidity in adolescent mental health); Deliberate Self-Harm (2004, recently updated to cover the longer term care of patients who self-harm) and Eating Disorders (National Institute for Health & Clinical Excellence, 2004). None of these were referred to by participating GPs in the interviews.

Without the structure of either nationally or locally agreed expectations and 'gold standards' (or quality indicators) consultations with young people who experience mental health problems accrue no financial reward; unlike the management of common mental health problems in adults. Currently, less than 3% of QOF indicators relate to children and young people (Royal College of General Practitioners, 2010: 7)

The conflation of there being no nationally agreed role and no financial remuneration (as rewarded under the QOF) for work undertaken in adolescent mental health results in GPs operating in a vacuum and determining their own response as individual practitioners; a response which is shaped by a plethora of individual, practice, regional and nationally based influences.

However, the existence of Quality Outcome Framework is irrefutable and the underside of a 'QOF-able' world (Campbell and Lester, 2010) is that access to primary care appointments has been prioritized over continuity of care. This was a strong theme in the data. GPs working as *fixers* used it to explain their minimalist approach; GPs working as *future planners* saw appointment booking systems as an obstacle to developing trusting, empathic relationships and GPs working as *collaborators* developed ways of surmounting rigid systems to maintain continuing relationships.

The studies by Checkland et al and McDonald et al reported in Chapter Two describe a 'new culture of general practice' where GPs make 'discursive

claims about providing holistic care' (Checkland et al., 2008) in which they create a metaphorical 'protected' space within the consultation in which the GP could remain 'patient centred'. However, as models of social behaviour reveal, including Foucault's regimes of practice (Foucault, 1991) and Giddens' structuration theory (Giddens, 1984), actors both contribute to and respond to the context in which they operate. Hence, whilst the participant GPs largely felt QOF to be marginal to their engagement with young people who experience emotional distress, they will also be responding to the constraints imposed by QOF which will both 'push and pull' their consequent behaviour. Since elements of this behaviour are operating at an unconscious level, an analysis from participants is not always available in the context of a research interview. The data generated confirmed this. Thus, within the interviews there was less of a discussion about QOF's impact on promoting discontinuity of care yet the GPs recognized that obstacles to offering appointments with the same GP impacted negatively on working with young people in distress.

Finally, work cited in Chapter Two which interrogated the changing landscape of contemporary 21st century general practice describes an 'effacement of the social' in favour of 'a theatre of technical competence' (Charles-Jones et al., 2003) which has led to a marginalization of responses to psychosocial problems in general practice. Charles-Jones et al conclude from their ethnographic study that patients with complex mental health problems and terminal ill-health are seen to be the two remaining out posts where a GP can enact the 'traditional' roles or identity of 'the family doctor' (2003: 72).

Competing epistemological frameworks in general practice

A GP's preferred knowledge framework was considered to be one of the pillars of the proposed theoretical model in determining how a GP enacted their role towards a young person in emotional distress. It appears pivotal in determining their degree of engagement.

The Fixer

GPs portrayed as *fixers* dominated the literature. Biddle et al's landmark study (Biddle et al., 2006) which examined how young people perceived GPs as a source of help for emotional distress demonstrated that 'the GP' is seen as a '*fixer'* who is mainly interested in physical problems, less inclined to initiate dialogue about emotional concerns and more likely to offer medication or a referral than a therapeutic conversation. Such was the dissonance between need and perceived likely response that some of the young people interviewed in the study (aged between 16 and 24 years) chose self harm as a preferred option to consulting with a GP.

The prerogative of the biomedical model, the favoured paradigm of *the fixer*, to favour diagnostic labels above clinical engagement was seen in the literature with respect to Illiffe's earlier study (2008) where GPs were uncomfortable making a diagnosis of 'depression' in young people and as a result were hesitant in initiating a therapeutic dialogue. The GPs participating in Illiffe et al's study saw teenagers as a 'separate and difficult patient category' who 'intermittently and impulsively' used GP services and who, if presenting with emotional and behavioural changes, were considered to be 'going through a phase' which would not be helped by adding a label of 'depression'. The authors concluded that GPs gave 'greater weight to the hazards of labelling unhappiness as depression than to the identification of depression and intervention to minimize current and future impairment' (2008: 276-7).

The function of the *fixer* is perceived to be in naming the patient's problem and to accord a diagnostic label which places the doctor and patient at a distance from each other and can result in the doctor 'sheltering behind biomedical labels or disease categories of uncertain benefit' (Dowrick, 2009b). Such an approach is unlikely to encourage disclosure of emotional difficulty and will compound the difficulty young people might have in speaking openly about their emotional worlds with a health care professional.

The *fixer's* frame of reference is predicated in the biomedical model which sees its ontology and epistemology as unimpeachable and authoritative, and

as such affords no weight to the fragmented and incoherent story which a young person might bring to the consultation such as, for example, having fallen out with their 'best friend', or constantly arguing with their parent/s or poorly attending school. The notion of (bio)medicine adopting the ultimate authoritative position in relation to other ways of understanding bodily malfunction has been argued by the philosopher Michel Foucault in his theoretical development of the concept of the medical 'gaze' (Foucault, 1963) (Foucault, 1975a); summarized below by a Foucauldian scholar

> *It is the gaze that emanates from a site of power and authority, always already appropriating the right to look and to see, attempting to do so hegemonically, and thereby invisibling/silencing other perspectives/gazes.* (Clarke, 2005: 58)

The effect of holding such a gaze upon a patient is to distance the doctor from a patient's suffering and was found in the archetype of the *fixer* who remained objective in the face of distress and who justified this response by not considering emotional wellbeing as a 'legitimate' area of practice for a GP (contrary to policy recommendations).

It is known from the epidemiological studies (referred to in Chapter Two) that the majority of young people with emotional distress secondary to psychological difficulties are 'invisible' to heath care practitioners until adulthood, by which time many will have been experiencing psychological morbidity for 5-15 years (Kessler et al., 2005) thus supporting the idea of 'hidden needs' (McGorry et al., 2007a) and a silencing of distress in this age group.

The Future Planner

The literature also included evidence of GPs operating in the biographical-biological perspective. This is an epistemological perspective which recognizes the particular biology of an individual, their genetic inheritance and their pattern of vulnerability within the social context of a family and community. It is a position which is more likely to resist the uncritical acceptance of disease labels and sees the benefit

....of holding the border between subjective illness and the
disease categories recognized by biomedical science; of confining
people within those categories only when such labelling will be
positively useful to them. (Heath, 2011): 6)

The study by Jones and & Green (Jones and Green, 2006) which examined the discourses of salaried GPs found a pragmatic *modus operandi* amongst the salaried GPs consistent with the *future planner* archetype which prioritized encouraging patient autonomy. At a conceptual level this was more about de-coupling patients and doctors, than it was about empowering patients; thus freeing up the 'new' (salaried) GPs for 'nice work' which was uncomplicated by emotional dependency from patients (2006: 931). The data supporting the notion of the *future planner* echoed this desire for patients to be independent and for the doctor to focus on equipping patients with the tools which would promote and maintain their self-regulation.

The Collaborator

The genesis of this archetype resides in the paradigm of interpretive medicine and was supported by a (small) number of papers found in the literature review.

To review Reeve's definition, interpretive medicine is

the critical, thoughtful, professional use of an appropriate range of
knowledges in the dynamic, shared exploration and interpretation
of individual illness experience, in order to support the creative
capacity of individuals in maintaining their daily lives. (2009: 62)

The acknowledgement of multiple knowledge frameworks does not foreground one perspective alone and recognizes that to help construct meaning about the distress which a young person is experiencing, a practitioner needs to accept a plurality of truth. In doing so, part of the role of a collaborating GP is to validate the patient's suffering and to make the distress '*more comprehensible, manageable and meaningful*' (Heath, 2011: 21).

The conceptual model proposed in this thesis supported an archetype which prioritized relationship centred care, which is in contrast to the doctor dominated *fixer* style and the doctor led *future planner* approach. Not only does the *collaborator* consider the young person's perspective and tries to imagine how they might be feeling, as they sit opposite the doctor, but the collaborating GP uses her/himself as a therapeutic tool through the vehicle of the doctor-patient relationship.

In her Harveian oration (2011) Heath speaks compellingly of the centrality of relationships to human thriving

> *Relationships help to create meaning and are fundamental to human existence.* (2011: 21)

Heath argues that it is

> *....these qualities in the relationship between patient and doctor (which) will be proportionately more important for those who whose lives have been irreversibly marked by abusive and destructive relationships....*
>
> *One of the key roles of the doctor is to work with patients to find an explanation of what is happening to them.* (2011: 22)

Where this approach is successful the patient will feel less afraid and more hopeful, despite their co-existing emotional distress. Given the accepted emotional lability of adolescence, in part secondary to biological changes, coupled with evidence from the (qualitative) literature which captures the sense of isolation which many young people have reported to experience at times of psychological need (Rickwood et al., 2007, Gould et al., 2004), adolescence represents both a time of need and opportunity. Young people are more likely to benefit from an empathic practitioner who is interested in 'meaning making' which makes sense for the patient concerned.

Data describing vignettes gathered from GPs operating as *collaborators* demonstrate that it is possible for GPs to work in this enabling way in which 'the creative capacity of patients' (Reeve, 2009) is encouraged.

Clinical practice which adopts this hopeful stance is supported by the paradigm of interpretive medicine which includes the practice of narrative medicine allowing patients to 're-tell' their story for the

> *The suppleness of narrative contrasts strongly with the fixed nature of much biomedical labelling.* (Heath, 2011: 22)

By creating alternative versions to a story of sadness, loss and pain a relationship-centred model promotes healing and nurtures the patient's own creative capacities both in the present but also as a resource to be drawn upon when needed in the future.

An emerging thread which appears in the cognate literature exploring 'the therapeutic relationship' concerns the role of compassion. In this study doctors practising collaboratively described a compassion towards young people, with whom they had worked, which seemed to come from a moral commitment to respond to suffering; also described as a 'duty of care'. Compassion as a clinical 'skill' is emerging in the lexicon. This is seen in the development of Compassionate Focussed approaches to CBT as developed by Paul Gilbert at the University of Derby (Gilbert, 2009); and of the influence of the wisdom traditions upon psychotherapy (Germer and Siegle, 2012) and upon CBT with the development of mindfulness CBT (Siegel et al., 2002).

Compassion is associated with empathy and together they guard against professional cynicism and encourage clinical engagement, both never more necessary than when a patient is least able to articulate their need, and yet most needs help (Roberts, 2009). As the narratives of the participants in this study revealed, supported by the (limited) literature, this is often the case for young people experiencing psychological difficulty. Often unaware of their own needs and unsure about what it is they are experiencing, they struggle to voice their felt experience and require an attentive listener who does not pre-judge or make assumptions based on the external appearance.

Dealing with uncertainty and anxiety in the consultation

This was a dominant finding evident from the earliest data collection. It was also found in the literature although often in the context of general practice as a theoretical and practical endeavour; rather than specifically with regard to working with patients experiencing emotional distress. Studies which described the latter were identified and will be discussed later in this chapter under the section *Managing adolescent emotional distress in General Practice.*

The study by Geneau presented in Chapter Two (Geneau et al., 2008) suggested that GPs experience a sense of *ontological insecurity* when they are uncertain how to proceed in certain clinical territories, especially where the territory is unbounded and the clinical content unpredictable. The authors used a case study method to derive four conditions which help control uncertainty. The findings from Geneau et al's study (2008) illuminate the situation of adolescent mental health and its parallels with its lack of professional remuneration; the inconsistent access to 'other (medical) resources'; and low patient demand (low on the part of young people in emotional distress, although the need is high). Where these conditions conflate professional anxiety is increased creating *ontological insecurity.* One response is for GPs to adopt the *modus operandi* as *fixers.*

A cogent reason for GPs feeling uncertain of their practice in this cognate area is their reported lack of preparation. Consistent with data from this study which reported scant, if any, undergraduate attention to adolescent mental health the GPs unanimously felt ill-prepared when working in this clinical area. This has been reported in a number of studies (Viet et al., 1995, Cockburn and Bernard, 2004, Churchill, 2008) and consistent with such studies, GPs report a desire for more education in this clinical arena (Bernard et al., 1999, Cockburn and Bernard, 2004).

Uncertainty can lead to a 'closing down' of discussion, or a reluctance to 'open up' discussion, and this was seen in a paper by two Norwegian psychiatrists who conducted a qualitative study using focus groups to 'gain

insight into the management of child and adolescent mental health problems by their GPs'.

The authors observed that 'there were few if any personal reflections' in the focus groups of GPs they conducted, which they assume is a desire 'not to reveal incompetence in front of their (psychiatrist) interviewers'. The authors' remarks suggest that they were expecting GPs to share their uncertainties yet found them unforthcoming (Hafting and Garlov, 2009). Data generated in focus groups offers different discourses and ideas, when compared to the data generated in conducting individual interviews (Barbour and Kitzinger, 1999), and the contrasted findings here may in part be explained by methodological differences. They may also reveal that it is difficult for GPs to share their anxieties about managing certain conditions when they perceive a key function of their role is to 'problem solve'.

The management of emotional distress in general practice

Literature presented in Chapter Two demonstrated the growing and key role GPs play in the management of emotional distress in adult populations. Research discussed here also laid bare the paucity of tradition in the medical literature of doctors accepting the role and impact of social determinants of poor mental health. The chapter documented an emerging narrative of the importance of seeing the causes of depression (as the key mental health problem studied) being social in origin; not least because this is closer to how many patients see their situation (Karasz et al., 2012). A gradual shift from an adherence to both viewing, and responding to, depression from within a biomedical model is occurring, but it is against a background of a tradition of not validating the social origins of distress. Research conducted ten years ago, exemplified by studies from Dowrick & May 1996) and Armstrong & Earnshaw (2004) documented the reluctance of GPs to acknowledge social issues as being of significance. This historical precedent helps to explain the reluctance of (some) GPs to prioritize a social history with young people who experience distress; exacerbated by the uncertainty of what to do with such information.

The trend towards a greater contextualization of emotional distress, seen in examples of work which incorporate an agenda for community development, is promising. One such example is

> *the AMP (improving Access to Mental Health in Primary Care) research group (which) is testing a new multifaceted model of care designed to improve access based on three interlinked components which include community engagement; primary care development and sensitized psychosocial interventions.* (Dowrick, 2009b: 637)

This broader perspective would appear to have much to offer to the potential range of responses to emotional distress in young people.

A greater acceptance of the social determinants of mental ill-health would also invite greater consideration of the structural inequalities which are well known to result in social gradients of illness (Marmot, 2008) including mental health problems. Analysis which interrogates trends in adolescent health asserts that 'the trends in adolescent health are strongly linked with health inequalities' (Viner & Barker, 2005, Viner et al., 2012). A recent Lancet paper incorporates the analyses of the international team of authors to conclude that

> *the strongest determinants of adolescent health are structural factors such as national wealth, income inequality and access to education.* (Viner et al., 2012)

Risk behaviours around substance use and 'antisocial behaviour' are likely to contribute to the development of health and social inequalities (West, 1997, Koivusilta et al., 1999). Awareness of the impact of a young person's social history may be poor amongst GPs; no studies which specifically interrogate this concept were found during the literature search. Data from this study showed only a patchy awareness of the social determinants on a young person's psycho-social and emotional wellbeing. No GPs acting as *fixers* discussed this aspect in their interview and only a small number of GPs operating as *future planners* were cognizant of the interplay of factors.

As discussed in the preceding chapter it is the *collaborators* who include a social critique in their approach to responding to adolescent emotional distress. They recognize that societal constructions of adolescence, often simplistic and pejorative, may impact on how young people present and how adults might respond. An ability to look beyond the external appearance and consider competing tensions is part of the collaborators 'tool kit'. This *modus operandi* was seen in other examples in the literature of how GPs respond to emotional distress.

Davidsen's study, discussed in detail in Chapter Two, presented the psycho-analytical idea of *mentalization* which she mapped onto a phenomenological analysis of research interviews with participating GPs. Her analysis found three dominant modes: from high to low mentalizers, with a middle group; a finding which maps to the conceptual model of 'the enactment of role' presented in this thesis.

Another study which both supports the findings and suggests a way forward in supporting greater engagement of GPs with troubled young people is the work by Cocksedge et al describing 'holding' relationships. This concept is a development of earlier work on pastoral relationships in general practice (2005). Although Cocksedge focused attention on the quality of relationships which GPs formed with their adult patients, the models advocated correspond to elements of the conceptual model presented in Chapter Five. Of the three models described (discussed earlier in Chapter Two: 33), it is the model of 'interim holding' which shows greatest resonance with the *collaborator* archetype.

If a GP and young person are able to work together and invest in a continuous relationship, even if this is only over a stretch of several months, as described by Cocksedge in 'interim holding' (2005: 160) then the relationship may be sufficiently supportive to help the young patient cope with a period of adversity such as parental divorce, a family death or a new diagnosis of a serious illness. 'Holding relationships', articulated in a later paper, include the value of 'partnerships' in the doctor-patient relationship which are perceived by patients to be offering emotional and social support

to deal with narratives of 'current and past hardships, including child abuse, domestic violence and bereavement' (2011: e487). Cocksedge's work demonstrates a working model which maps well to the proposed *collaborator* archetype.

Young People's mental health in general practice

Data generated in this study showed that GPs viewed presentations of emotional distress by young people as complex. With regard to young people presenting in general, their views depended on where they were positioned on the threes axes concerning their performance in the clinical encounter; their views of young people and their health needs and their preferred epistemological frame of reference. *Fixers* tended to see youth health as 'straightforward' and centring on 'acne, coughs and colds' (01; M; 50-59;S); *future planners* appreciated a greater depth to the 'presenting complaint' and might see a request for contraception as an opportunity to discuss sexual health and relationships more broadly; *collaborators* viewed presentations as 'pieces of a jigsaw'. (10; M; 40-49;P).

In general the extant literature which looked at GP management of adolescent emotional distress represented a picture of GPs as largely working as *fixers.* Work by Martinez et al (2006) found GPs to be reluctant to discuss emotional difficulties with young people and hesitant to respond to cues. Even where GPs in this study did identify problems, they offered only a small percentage of the identified young people a management plan with booked follow up; suggesting a professional uncertainty about how they might proceed.

This uncertainty was compounded by a perception amongst *fixers,* both in the data and the literature that young people were 'difficult to talk to'. Recent data (Balding and Regis, 2010) included in the latest Key Data on Adolescence (Coleman et al., 2011) reported high levels of uneasiness experienced by young people in consultations. There is (albeit limited) evidence around GPs shortening their consultations with young people (Jacobson et al., 1994), (Churchill et al., 2000) which although now dated, may resonate with the work by (Mercer and Watt, 2007). Mercer suggests

that GPs working in areas of high social need often run at shorter consultation intervals as a consequence of self-protection and an attempt to limit the tide of (potential) demand. Within the empirical date presented here, there was a view expressed that consultations with young people could be kept brief because "teenagers do not demand your time" (07; M; 40-49;P). What is needed is a recognition that it is GPs who make the choice about whether additional time is offered or not. How GPs choose to respond depends on their position on the axes of the conceptual model.

GPs who worked more co-operatively with young people recognized that the language used by the doctor is critical in setting the tone of the consultation. Use of naturalistic, vernacular speech with local idioms was seen as helpful in establishing a more comfortable relationship. This was also seen in the literature with the value of using 'lifeworld' speech placed in contrast to 'the medical voice' (Barry et al); in a study based upon Habermas' Theory of Communicative Action (Ritzer and Goodman 2003: 529). Furthermore, whilst doctors could be seen to switch between 'voices' the authors acknowledged that 'structural aspects of the healthcare system would require attention' to support a change in practice. This resonates with the doctoral study reported here which shows that the context in which doctors work both shapes and is shaped by clinical practice.

Literature which examines *the situational awareness* of doctors corresponded to the relative dimensions of the conceptual model and referred to the 'morality' of engagement (Katz and Alegría, 2009). Reference to Goffman's 'language of relationships' (Goffman, 1963) exemplifies the conceptual model's description of relationship centred care as core to the *collaborator* archetype.

In the final part of this section the findings reported regarding GPs' ability to detect emotional distress are compared to the extant literature. Numerous studies suggest that GPs are poor at detecting psychological problems in adolescence (Kramer and Garralda, 1998; Kramer and Garralda, 2000) , and other internationally referenced work (Hickie et al., 2007). Such studies found GPs to have low sensitivity rates for detecting mental health problems unless

they were of a severe nature (leading to high specificity rates). Again, this picture resonates with GPs who are presented in the literature as largely operating as *fixers.* This simplistic picture is contested by the conceptual model presented here which represents GPs working along a continuum. The more a GP can operate in the interpretive paradigm the more likely they are to undertake a dialogue which permits a young person to share a narrative of emotional difficulty. The more a GP 'ventures from the shelter of diagnoses and interventions of uncertain benefit' (Dowrick, 2009: 637) couched within the biomedical paradigm, the more they are able to work in partnership with the patient. The recent study by Illiffe et al (2012) confirms this by finding that the use of the word 'depression' stymied GPs; with the authors' singling out defining 'depression', and using the word 'depression' with adolescents, as the most difficult task discussed by study participants. Where GPs can move away from this knowledge framework and into a more interpretive paradigm they can minimize the anxiety around their performance in this cognate area.

The strengths of the study

This study aimed to explore GPs' views and experiences of managing emotional distress in young people. Using a grounded theory approach, augmented by situational analysis, a conceptual mode has been developed. The relative strengths and limitations of the study design will be critiqued below.

The strength of the conceptual model

With regard to the conceptual model proposed in this thesis a key strength appears to lie in its theoretical generalizability to conditions other than adolescent mental health. The uncertainty and professional anxiety which are associated with consultations concerning young people experiencing emotional distress may be magnified in this clinical arena, as the data suggests, but they are not unique concepts within the practice of general practice, as the section on '*Dealing with uncertainty and anxiety in the consultation'* (see Chapter Two) demonstrates.

The two areas of clinical practice which offer the greatest commensality lie in managing enduring emotional distress in adults with complex psychosocial narratives and with adult patients who have a diagnosis of a terminal health condition. In the former there is an increasing interest in drawing upon perspectives which ultimately derive from the wisdom traditions' (Epstein, 1999, McWhinney, 2000). This new paradigm, as Dowrick discusses (2009: 637, Dowrick, 2009a), focuses on the alleviation of suffering (Cassell, 1982) as the doctor's goal, rather than the 'concept of depression as a disease' (ibid.) This approach is enriched by a narrative approach to emotional distress (White, 2007) which aims to create a series of mutually constructed maps of a patient's narrative, in order to thicken their account of the 'unique exception' or 'the preferred story' in the patient's account of their distress. Narrative practice explores the underlying values which shape choices and which deeply influence human behaviour.

Research into working with patients with a diagnosis of a chronic or incurable condition have looked at the impact of such a diagnosis on self-identity and the 'biographical disruption' it creates (Bury, 1982). Reeve et al have written extensively on the work patients must undertake to lead a coherent life in the face of such a disruption and of how healthcare practitioners can work with the patient to build a new, adjusted 'personal narrative of self-identity' (Reeve et al., 2010, Reeve et al., 2011).

Charles-Jones et al (2003) identified these two clinical areas (of complex adult mental ill-health and terminal illness) as being the two remaining out posts where the GP can still inhabit the role of the traditional identity as a 'family doctor' (see Chapter Two: 17). The theoretical model proposed here serves as a template for understanding how and why this might be. Doctors who operate as *fixers* are likely to feel ill-equipped to work with adults with complex mental health needs or as the patient approaches death. *Future planners* will have a number of strategies they can call upon but are likely to feel frustrated if their pragmatic approach is not adopted by the patient or appears 'not to work'. GPs working as *collaborators* would be best placed to work with these two groups of patients as they journey alongside each other to work collaboratively to make sense of the experience.

The strengths of the study

This study sought to explore a relatively unexplored subject. In order to examine the unknown territory in detail grounded theory was chosen as the most apposite methodology and applied in the form of *situational analysis*. General practice, as a setting for undertaking research, is a rich and eclectic milieu with a complex socio-political history; and the depth of *situational analysis* allows for consideration of the myriad of competing influences operating in this space.

Situational analysis

> *'All readings are temporary, partial, provisional, and perspectival - themselves situated historically and geographically. (*Clarke,2005: 8)

To explore GPs' views and experiences of consulting with young people with emotional distress, in order to arrive at a deeper understanding, would require a methodology that was suitably flexible and sensitive to the cultural context of general practice. By taking a grounded theory approach, the researcher did not approach the field with hypotheses which the empirical data would seek to confirm or refute. Thus, it did not pre suppose what *might* be influencing GPs, although the study design would be cognizant of the structural scaffolding of general practice and its history.

As discussed in Chapter Three, *situational analysis* is grounded theory taken through 'the post-modern turn'. This translates into being a new 'theory-package' form which takes into account some of the limitations of the earlier forms of grounded theory. Clarke summarizes these modifications of 'pure' grounded theory to include a new prioritization of reflexivity; a resistance to 'over-simplify' findings by tending to focus on commonalities, and to dismiss data which the researcher sees as being 'contrary' or to see 'outliers' as 'negative cases'.

The study presented here aimed to honour those precepts of *situational analysis* and will discuss the role of reflexivity in the data analysis in detail below. It assumed from the outset that no researcher's position is 'innocent'

and that all knowledge is situated. For a researcher who is located in the positivist domain such an ontological position would undermine the very integrity of her or his work. For a researcher operating in the interpretavist domain such an acknowledgement frees them from pursuing the' absolute and final truth' and opens the field to multiple interpretations, all of which must be subject to the rigour of the reflexive process.

Theoretical Sampling

A foundational tool of the methodology used here is the process of theoretical sampling. As described in Chapter Three, this method of data collection follows the development of the emerging themes and at the same time dismisses those early ideas which, after the constant comparison method, are seen not to acquire theoretical weight, allowing them to be discarded.

Despite the expected difficulties of recruiting busy practitioners who work in a clinical environment which does not necessarily prioritize the value of exploratory research, and where 'the randomized controlled trial' is held in higher regard; this study pursued the recruitment of participants in keeping with the emergent theoretical ideas. In so doing the analysis has a rigor which would not have been achieved by an alternative sampling strategy.

Each of the participants in this study was selected on the basis of their ability to add, to challenge, and to test dominant ideas as they appeared during the iterative analysis. One result of this methodological approach was the interrogation and ultimate collapse of the early suggestion that gender and age might determine how likely a GP was to engage with young people. Recruiting GPs whose age range spans from 29 to 59 years of age allowed for the exploration of the idea that it is younger GPs who find consulting with young people 'inherently' easier and to see this early idea tested and ultimately rejected as theoretically empty. Similarly the early suggestion that female GPs found it easier to talk with adolescents than did their male counterparts was also challenged by recruiting an equivalent number of female: male GPs.

What the data did demonstrate was a gender distinction regarding patterns of communication amongst young people. Young women were regarded by the participants as generally being much easier to talk to than young men. Furthermore, when young men did present in surgery it was almost always indicative of serious and enduring emotional distress which would require an appropriate response from the GP.

The participants worked in a range of geographical and socio-economic settings which was important to the study because of the contextual nature of psychosocial difficulties in younger people. For example, those GPs working in more affluent areas spoke of the family and scholastic pressures placed upon teenagers in professional families where there are high expectations of achievement. This was in contrast to accounts from GPs working in economically deprived regions who spoke of the low aspirations amongst their patient populations (with a small number of *collaborator* GPs referring to the limited range of options available to young people). In these contrasting economic settings the professional expectations to respond, which were experienced by the GPs, were quite different and thus would have an impact upon the enactment of their professional role.

Theoretical sufficiency was achieved after interviewing 19 GPs. By the 19th interview no new themes were appearing and adequate theoretical depth had been achieved through the multi-stranded collection of the empirical materials.

Reflexivity

The importance of reflexivity as a central plank to grounded theory and, by implication, *situational analysis*, was discussed earlier in Chapter Three. Given the nature of the topic to be discussed in this section it will be written in the first person, unlike the rest of the thesis which is presented in the third person.

The Introduction in Chapter One outlined the multiple influences upon which I as a researcher draw and which exert their influence during the process of analysis and interpretation, both tacitly and covertly. Reflexivity aims to address this fluid process and to reflect critically on the self as researcher.

My own embodied, intellectual and experiential knowledge, that which Clarke refers to as *a constellation of official and unofficial knowledges* ((2005: 12), will sit at the heart of how I gather, analyze and interpret the empirical data. It has also influenced the choice of research topic.

It can be a temptation to draw upon personal and professional experiences which arise outside of the research process and it requires active reflection to maintain an awareness of one's position, in order to use this broader knowledge to inform the analysis but to remain grounded in the data. Corbin suggests:

> *Experience is an analytical device used to stimulate reflexion about the data at hand* (Corbin, 1998: 122)

The process of doctoral supervision was essential in order to keep alert to the interweaving influences from occupying multiple roles as a clinician – researcher and to promote my focus on 'the data'; for this is where the 'golden nuggets' are to be found:

> *By studying the data line by line, you may make fundamental processes explicit, render hidden assumptions visible, and give participants new insights.* (Clarke, 2006: 55)

The inter-connectedness of our knowledge and the roles we perform act as a lens though which we interpret what we see. In this study it also informed how the data was gathered, given that a one-to-one interview is a creative act. The nature of the subject matter provoked reflection for the majority of participants and the manner in which their thoughts and experiences, about this complex area of clinical practice, were communicated, reflects the contemplative quality of the majority of the interview encounters.

I endeavoured not to present myself in any way as an 'expert' on this clinical area but as a peer, albeit an academic GP, with an interest in adolescent mental health and with a curiosity about what happened in practice. By being aware that I might be perceived as more knowledgeable I paid attention to my language and non-verbal communication in order for this not to happen. On reflection, I consider that this improved as I became progressively more

comfortable with the interview process and I could concentrate more at putting GP interviewees at their ease, rather than focusing on my behaviour as an interviewer.

A number of participants seemed to want approval for their remarks, often at the closure of the interview, despite my assurance that this was an exploratory piece of work which did not seek to 'find out answers' but rather to better understand a complex area of practice. I was also very aware that for a number of participants the interview presented a rare occasion to discuss problematic aspects of consulting with young people and they appeared to value this opportunity.

The analytical tools of situational analysis

The rigour of the coding and sampling techniques employed in this study were further strengthened by the use of the cartographical tools of *situational analysis*. The three analytical devices which Clarke describes as 'the tool box' of her theory/methods package were summarized in Chapter Three. Taking each in turn this section will briefly summarize the value of using these tools to supplement the grounded theory analytical process and draw the reader's attention to the examples of each of the tools which are located in the Appendices.

Firstly, the *situational map* served as a 'journal' to which new words and phrases could be added as they entered the lexicon of the situation of inquiry. Clarke suggests keeping both a 'messy' and an 'ordered' version with the ordered format giving the researcher the opportunity of grouping domains. 'Ranking' ideas and codes in order of importance as an analytical technique was avoided since it accords a weighting which seems more in keeping with an 'objective', positivist approach. As a tool to aid data analysis the *situational map* reminded the researcher of the competing influences upon the situation of inquiry whose magnitude of influence cannot be fully appreciated until the data analysis is complete.

The second tool, the *social world/arena map,* which offers a 'meso-analytical framework of the relationships between individuals and as members of social worlds' (see Chapter Three) is a supporting device to the *situational maps*. It

aids the development of understanding how competing factors interact with each other and with what magnitude, since some directions of travel are more significant than others. For example, creating early pictorial diagrams demonstrated how much the anxiety and uncertainty for GPs when working in this area dominated the landscape and tended to push to the margins the young person's perspective. Similarly, the role of a relationship between a GP and the local CAMHS team appeared as peripheral in the early stages. As the analysis deepened it became more apparent that the closer was the relationship between the CAMHS team and the primary care clinicians, then the more pro-active were the GPs in engaging with young people with emotional distress. In contrast, where the two professional groups had little contact, tension and mistrust were more evident and the GPs in this situation tended to be much less likely to engage in clinical encounters where the young person may well have been experiencing psychological difficulties.

The final tool, the use of *positional maps,* offered an additional theoretical weight through revealing 'hidden' ideas and relationships. As Clarke writes

> *..they allow the researcher to see possible positions which are not taken in the data, positions that remain unarticulated. (*2005: 136)

Although drafting *positional maps* seemed *'procedural, formal, even formulaic'* (ibid: 136), when performed for this study they proved illuminating. They made clear the negative association between doctors choosing to remain 'in control' and, as a consequence, experiencing higher levels of anxiety than doctors who shared responsibility for defining 'the problem'. The maps articulated the subtle influence of experience and skilful communication which could moderate an overly 'doctor-centred' approach. Such an approach was shown by the data to have an adverse impact where the doctor was less experienced.

The *positional maps* offered the greatest theoretical insight through deconstructing the elements of 'power' in the consultation. By deriving axes which explored greater or lesser adherence to the biomedical model and looking at such a position, and its impact on engagement (see appendicesE5-8), the use of power in the consultation was explored. In this

respect the function of the *positional maps* in the analytical process was highly significant.

Conceptual maps were also constructed throughout the analytical process, particularly in the period leading up to the development of the three axial codes. A number of examples are included in Appendix F.

The Limitations of the study

> *All aspects of human being and knowing are situated.* (McCarthy, 1996: 107)

All studies are flawed and imperfect. Critiquing an interpretative study can be problematic if the reviewer assumes a positivist stance as certain aspects which seem 'ripe' for criticism are an elemental aspect of the ontological framework. Interpretative research assumes partiality. This is not so much a limitation as integral to the enterprise and underpins the underlying epistemological and ontological framework.

The 'situatedness' of the knowledge generated *is* its strength but at the same time it has to be recognized that it leads to particular choices being made in the analysis. Where one theoretical route is followed, however robustly the choice is defended, other potential directions are left untaken. There can be no 'validated' assuredness that the route taken is the 'right' one, only theoretical robustness to support the decisions made. In other words

> *In a good grounded theory analysis it is routinely possible to see how things could have been otherwise.* (Hughes, 1971)

Decisions which the investigator makes early on about the strength of emerging themes inevitably reflect the position of the researcher. These early and often inchoate concepts will inevitably guide *"directions about where to look but not about what to see"*. (Clarke, 2005: 77).

Partiality

The dynamics of power as a potential over-arching theoretical construct was explored during the data analysis but its explanatory potential to address all

of the data was left wanting. However, it might have been possible to have further interrogated the data or continued recruiting additional participants in order to further develop the idea of power as a selective code.

Other theoretical possibilities which presented themselves as potential routes for further interrogation included exploring the concept of emotional literacy amongst GPs or looking at personality and its relationship to consultation style and practice of medicine. A final idea was in the form of organizational culture and a study of the role types which are said to exist within an organization, as described by Belbin (2010).

Three potential limitations of the study have been identified. These refer to triangulation; the influence of prior contact with participants and the cultural homogeneity of the sample.

Triangulation

Triangulation, a term derived from trigonometry, refers to the process of geometrically determining the location of a point by measuring angles from known points at either end of a fixed baseline. As a concept it has been introduced into qualitative research to buttress the rigour of the process and to 'enhance' the 'validity' of the data; although given the interpretive paradigm of the majority of qualitative research 'validity' is a contestable notion. Triangulation has been defined as

> *A research technique in which a researcher compares the findings of different methods and the perspectives of different people or groups to help produce a more comprehensive set of findings.*
> (Kuper et al., 2008)

The appropriateness of triangulation is problematic within the interpretive paradigm because of the *a priori* assumption that there is *a* truth which can be confirmed by examining the data using a combination of different methods. As a result interpretavists have challenged how appropriate it is to use triangulation. A broader view taken is that triangulation can 'open' the data rather than test it for 'validity'.

Denzin (1989) had originally argued that theoretical and methodological triangulation elevates the researcher 'above the personal biases that stem from single methodologies' but has shifted his position in a fluid transformation that Lincoln describes as unsurpassed in genre blurring (Lincoln, 2004). Along with his co-author, Denzin has adopted a view on triangulation best described as

> *Triangulation is not a tool or a strategy of elevation but an alternative to validation.* (Flick, 2002)

The authors support the view that the analysis of interpretive research should be more 'crystalline' than 'triangulated' asserting that

> *Triangulation is the simultaneous display of multiple refracted realities.* (Denzin &Lincoln, 2008: 8)

Situational analysis as a 'theory-methods package' offers the multi-perspecitivity of robust triangulation. However, one aspect not included in the data analysis of this study is the technique of 'respondent validation' (also known as 'member checking'), which gives voice to the participants in the study:

> *to provide them with an opportunity to make judgements on the resonance of those elements with their own experiences.* (Kuper et al., 2008)

Originally it had been intended to carry out this process with a small selection of participants. However, inviting only a small sample would have made the process unsystematic and the usefulness of member or respondent validation has been said to be at its most robust when it is carried out systematically (Bendik and Munkvolv, 2007). Thus, although asking the participant GPs would have further enriched the analytical process the analysis was considered to be *theoretical sufficient* in the absence of a formal respondent validation.

Prior contact with participants

The second limitation of the study refers to the familiarity of the principal investigator with a number of the participating GPs who had been known to the investigator in other settings before the study, but not all of the participants.

Again, as with the partiality of interpretive research prior contact can be construed as both a strength and a limitation. It becomes a strength if it is seen as facilitating the interview by putting the participant at their ease and thereby promoting a comfortable interview in which the participant feels able to speak openly and honestly. In contrast, prior contact with participants may be deemed a limitation if it does not extend to include the full sample; although where the tenets of theoretical sampling are followed this would be an unusual sample, that is, where **all** the participants are known in advance of the study.

All interviewees, whether previously known or not, may be influenced by the 'Hawthorne effect' which describes the phenomenon of research participants changing how they might ordinarily respond as a consequence of being invited to take part in a study: see (Bowling, 2002: 219-220). This can lead to participants potentially shaping their narrative according to what they perceive the interviewer expects to hear. In the scenario of certain participants being known to the interviewer there may be a tendency to present themselves in a favourable light, offering a narrative which they imagine is consistent with the interviewer's position.

However, this human desire to present ourselves in a favourable light is not restricted to only those who had a pre-existing relationship with the researcher. Several of the GPs, including those who knew and those who had never met the researcher, sought reassurance about their comments during the interview as was mentioned earlier. Given the methodology of the study it is unlikely that prior contact with some and not all the participants has negatively impacted on the results.

The cultural homogeneity of the sample

The third and final limitation refers to the social demography of the participants who were all white British and all graduates from UK medical schools.

Little is currently known about how GPs respond to emotional distress in young people and why they choose to respond in the way that they do, or describe themselves as doing. Given the complexity of the phenomenon under scrutiny a considered decision was made at the outset of the study to focus on GPs who were familiar with the socio-cultural context of the North East by virtue of having practised there for at least three years, and in many cases having trained in that region. This would afford a degree of cultural congruity which could not have been assumed for GPs unfamiliar with the cultural mores and social history of the region.

Unlike other regions in the UK, the North-East is largely culturally homogenous (Large and Ghosh, 2006, North East Public Health Observatory, 2006). The largest social group contributing to cultural diversity is represented by the traveller community who form part of the patient population of at least two of the GPs included in the study. The North East also represents a region of high socio-economic deprivation (Hacking et al., 2011, Whitehead and Doran, 2011).

 Using regional databases from local PCO's it might have been possible to recruit GPs born overseas who had practiced in the region for a minimum period of an arbitrary minimum time period. However, such an approach would have introduced a layer of complexity into the analysis which might be more appropriately carried out as post-doctoral work. Such a piece of work would begin with an accepted theoretical understanding of the processes involved in the GP management of adolescent emotional distress and would build upon that foundation.

This original study aims to contribute to such a foundation.

Chapter Seven: Implications for future practice

Both the supporting literature and the empirical data indicate that young people experiencing emotional difficulties are ill-served by the status quo of current clinical practice. The conceptual model proposed both explains why this is the case and also offers a route map for promoting greater engagement with young people. GPs who gravitate to the *fixer* archetype respond poorly and counter-productively to patients with high levels of unmet need. GPs operating as f*uture planners* demonstrate a *modus operandi* which is much more hopeful and will lead to greater engagement if adopted on a wider scale. The *collaborator* approach affords the greatest potential for meaningful engagement through a therapeutic relationship which empowers the patient and can enhance their creative capacity.

GPs may arrive at this level of practice though their professional and personal development as individual practitioners. However, if current practice is to shift towards greater engagement on a significant scale there will need to be change on a much wider scale. Based on the findings of this doctoral study four domains have been identified as key to changing the way young people's mental health and emotional well-being is addressed.

These domains are education; the structural and cultural context of general practice; research and policy. Each will be discussed in turn although all the domains are inter-connected and cannot exist in isolation of each other.

Education

Underpinning any and all changes to current practice has to be a recognition that education, as the core framework for change, is pivotal. Education leads to a change in attitude as well as including the provision and delivery of new material to improve the recognition of early mental health difficulties in young people.

Undergraduate medical education

Data from this study found that all the participants, regardless of any demographic characteristics, spoke of either no exposure to (child and) adolescent mental health in their undergraduate education or of isolated

visits made to adolescent in-patient units. Here, the patient population was considered to be so unrepresentative of young people when compared to those with whom they were likely to come into contact as practising GPs, that it was viewed as counter-productive. There was evidence of a complete void in the undergraduate curriculum with respect to educational exposure concerning (child and) adolescent emotional well-being. An introduction to mental health as being the foundation of good health in general needs to commence at the earliest, most appropriate stage of the undergraduate medical programme.

Presenting a clear and coherent message that adolescent (mental) health underpins the subsequent development of an individual's life course, with the social determinants of health exerting a powerful and enduring impact (Marmot, 2008, Marmot, 2010, Viner et al., 2012) on adult health would make a strong case for a curriculum which reflects this reality.

Change at this level will require a philosophical, as well as a pragmatic commitment, to the importance of prioritizing young people's health. The leaders in medical education need to be convinced of the long term sequelae of ignoring emotional distress in adolescence and of the value of a timely response and early intervention. This needs to be underpinned by high quality research and a national commitment to investing in youth health; an area which has seen a reversal of historical mortality trends and where mortality rates amongst 15-19 year olds now surpass rates for 1-4 year olds, traditionally the group most vulnerable to death (Viner and Barker, 2005, Coleman, 2011). A conflation of an under-investment in preparing healthcare practitioners to be skilled in working with young people (Kennedy, 2010), an economic policy which does not address rising youth unemployment and at least 22% of children and young people found to be living in relative poverty (Layard and Dunn, 2009, Hudson et al., 2011) cannot be ignored. As referred to in Chapter Six, it is the structural determinants of health such as national wealth, income inequality and access to education which have the greatest impact on adolescent wellbeing (Viner et al., 2012).

Changing the focus

The theme of 'adolescence' needs to be cross-cutting and not delivered as an isolated or stand-alone module which would not adequately reflect the importance of incorporating a youth perspective in all branches of medicine (save the obvious exceptions which focus on 'old-age' medicine and its associated specialities.)

As such, 'adolescence' as a developmental stage, and incorporating a youth perspective, needs to be addressed in all the traditional clinical rotations, not only in the obvious contenders: Paediatrics, Psychiatry and General Practice. The transition from childhood through adolescence to early adulthood needs to be a feature of all specialities. The three listed provide more obvious opportunities to demonstrate 'youth-friendly' care through teaching sensitive and developmentally appropriate consulting skills; providing the opportunity to witness case discussions which raise issues of concern for a young person, not necessarily evident to an inexperienced medical student and to practise history-taking, using a holistic HEADSS type approach (McCabe, 1992 ; Goldenring and Rosen, 2004) (see Appendix G) in which the broad domains of a young person's life are considered, rather than a narrow focus on the 'presenting complaint'.

Extending the scope to include all specialities demonstrates the 'life course approach', in contrast to young people being represented as part of a 'sub' or 'special' group. Decades of unmet need (Viner and Barker, 2005, McGorry et al., 2007a, Kennedy, 2010) necessitate a correction of the status quo but there is a balance to be achieved between prioritizing the needs of young people and locating them apart, or indeed in competition with other age groups. Understanding the continuum of human development is critical to achieving this balance and as such must be cross-cutting across the curriculum. Teaching about 'adolescence' as a 'stand-alone' module would be counter-productive to such an aim.

Educational content

The period of time spent in undergraduate medical education is as much a process of *acculturation* (Sinclair, 1997) as it is a period of 'factual learning' or the accumulation of information. The key messages which are conveyed to medical students at this formative stage of their professional development will have a long lasting impact on their professional life conveyed through the *hidden curriculum* (Hafferty and Franks, 1994, Lempp and Seale, 2004)*.*

Medical education sits within the biomedical paradigm and although there have been innovations in pedagogic approaches, with problem based learning described as the most 'influential innovation in the last 40 years' (Wood, 2008) there is an undisputed hierarchy of knowledge frameworks which is reproduced in the undergraduate curricula. This suggests that the biomedical paradigm will continue to dominate medical education, with the biomedical sciences, including genetics, and technologically intense specialities of medicine occupying 'the top ranks' in medicine.

However, students can be introduced to other knowledge frameworks through disciplines within medicine and through the vector of other disciplines which work closely with medicine. Within the academy, general practice and psychiatry are two such disciplines which can introduce other epistemologies beyond the positivist paradigm (although psychiatry has at times often sought to foreground a neurobiological understanding of mental illness as the only orthodoxy (Dowrick, 2009a, Harrington, 2012).

Core content material which presents the common presentations of adolescent mental health problems needs to be delivered by both of the above specialities. The prevalence, chronicity and co-morbidity of psychological problems in this age group must be included in core curricula and ideally taught using high quality multi media resources which reflect a youth perspective and capture something of the vitality of young people. This is best achieved by working with young people themselves to present their perspective through the use of high quality audio-visual materials as teaching aids.

Including common youth mental health problems would address the consistent finding from this study where the majority of participant GPs were unaware of the high rates of first presentations of the 'affective disorders' which can occur in adolescence; typically co-existing with 'behavioural problems' such as 'anger problems', and 'conduct disorders', often confounded with alcohol and drug abuse.

Experiential learning (Kolb, 1984) as a valued pedagogic approach is undisputed and Paediatrics provides such an opportunity with students able to observe experienced clinicians consulting with sick children and adolescents, ideally referring to a broad framework which at best adopts a biopsychosocial model and resists a purely biomedical orientation.

Multi-disciplinary teaching

Of those disciplines which work closely with medicine, of key importance here is an early introduction to the CAMHS team. Ideally this should be through a structured educational session to display the skills profile and expertise of the community based team and would be a step forward to narrowing the gap between CAMHS practitioners and newly qualified doctors. The purpose of such a session would be to present to students examples of work-in-practice and show how the 'invisible' world of CAMHS operates. A positive first encounter with CAMHS can then be built upon through successive stages of the medical education programme including at GP Registrar level.

Continuing Professional Development (CPD)

Medical education can never be said to be completed and is a life-long project, needing to be revisited at regular intervals throughout a professional life. The current GP appraisal scheme (at the time of writing) promotes this adult-learner approach but by adopting self-directed learning does not impose child and adolescent mental health as a key priority; nor should it. Encouraging GPs to opt for CPD opportunities in this cognate area is best achieved through the provision of high quality, young person-informed 'Master' classes, such as offered by the BMJ Master class series or other reputable providers, including Deaneries (where these exist).

In addition, the role of peer supervision is important in CPD. With no formal requirement or structural provision for GPs to have clinical supervision these arrangements are essentially informal and more traditionally, if patchily, have arisen through Balint groups (Jones, 2011). Of late, CPD courses which teach mentoring skills are of immediate relevance. Mentoring skills encourage peer learning, especially in the 'grey areas' of clinical practice where ethical dilemmas or situations of transference and counter-transference arise to trouble the practitioner. The formal teaching of skills in coaching or mentoring (Viney and McKimm, 2010, Viney and Bhatti, 2010) has a two-fold advantage; such skills can promote peer supervision but also have a currency in developing transferable skills in the clinical setting, notably when adopting a *collaborator* approach to care.

Finally, taking up opportunities for further study in psychological therapies is also a way in which GPs can shift their *modus operandi* along the spectrum towards the *collaborator* archetype. Short courses in CBT and Solution Focused Therapy (SFT) (O'Connell, 2005) offer a different approach to talking with young people who experience emotional distress which do not focus on problematising a situation but rather on 'meaning making'. This suggestion is revisited in the section below.

Structural and cultural changes within general practice

The structural constraints imposed by the 2004 contractual arrangements have shaped general practice and been shaped by its actors in a myriad of ways. The contract and the QOF remain a continued focus of debate most often centred on the 'moral ambiguity and ethical concerns' which arise out of a 'payment for performance structure' (Kramer, 2012, Tonelli cited in Kramer, 2012) cautions that there needs to be an awareness of the inherent assumptions of patients' and doctors' 'best' interests matching, which clinicians have used as the moral defence since

> *the clinician needs to be aware that this may not apply to the individual patient who may have different value systems.* (Tonelli, 2007)

This is undoubtedly a likely scenario for young people with emotional distress who are so often unsure of what is happening to them and need from a clinician, an opportunity to understand their distress and seek a way forward. This scenario does not match well to a QOF dominated practice. It is beyond the scope of this thesis to develop an alternative structure to the QOF in order to promote clinical activity in the area of young people's emotional and mental health. However the conceptual framework proposed by this study demonstrates lucidly that adopting a slavish adherence to the QOF supports a *fixer* approach which is the least helpful with regard to engaging with young people. At worst it can cause distress by distancing the young patient and presenting a face of general practice which is disinterested in distress not conforming to biomedical categorization.

The consultation in contemporary practice

Consultation length

Depending upon which role a GP adopted, the views of GPs regarding the 'ten minute' consultation were mixed. In *fixer* mode the short consult was a disincentive to open up a conversation; in *future planner* mode it required the GP to structure their consultation and to retain a doctor led agenda; the *collaborators* saw the consultation as more plastic and often thought of the consultation length as 'multiple ten minute slots' or were more prepared to 'run late'. However this has implications for consultations with other patients and is an unsustainable approach to according more time to young people presenting with emotional distress.

There will need to be an organized strategy to enable practices to offer longer appointment slots without destabilizing the appointment system over all. Without a practice commitment, buttressed by a College and national commitment to introducing longer appointment slots it is difficult to see how emotional well-being in adolescence can be promoted.

 A recent editorial in the BJGP argues that given the increased demands upon the consultation a fixed 'ten-minute' slot will eventually become consigned to history. The authors cite three areas of challenge: the complexity of explaining risk, introducing opportunistic health behaviour

change discussions and 'the need for ongoing relationships and continuity of care in effective general practice' (Silverman and Kinnersley 2012: 118). They cite Ridd et al's study (Ridd et al., 2012) which reports a (weak) association between patient-doctor depth of relationship and detection of psychologically distressed patients. Other perspectives could also be included here including Moscrop's recent clarion call (Moscrop, 2011) to reawaken the psychodynamic potential of general practice as an antidote to the challenges of 'fast-shifting paradigms and increasing pressures in practice' (2011: 348). If the GPs' psychotherapeutic potential is to be harnessed longer consultation times are essential.

Consultation content

Although it is part of a broader shift in current practice, looking at what might be done within the consultation remains an important potential for introducing change at the level of structure and culture within general practice. The suggestions for what might be introduced at a CPD level, see above, included a recommendation for GPs to be offered training in CBT and SFT. This is part of a cultural change in terms of opening up what GPs might do in the confines of a (longer) consultation. The description of the *collaborator's modus operandi,* and a reference to the existing literature suggests that attentive listening and the validation of distress are key features of a therapeutic relationship which GPs are well placed to offer, given the right structural conditions and an appropriate epistemological frame of reference.

The literature review found evidence of GPs working with adult patients where resolution of the problem was not the focus of the consultation. This corpus of work included using the concept of *mentalization* (an extended form of empathy); and pastoral and *holding* relationships. How this might translate into therapeutic work with younger patients is yet untested but the literature reviewed offers the possibility of GPs doing 'different' work with adolescents who present with emotional distress.

Change at a practice level

Other changes to be made at a practice level which would improve the status quo would include practices nominating a 'lead GP' for (children) and young

people's mental health. Such a practitioner would not necessarily be expected to have a specialist clinical interest and may well be the 'children's health' lead but they would ensure that the mental health of younger patients would not be forgotten. A key role would be to establish links with the local CAMHS team and to be aware of local initiatives and agencies offering services to children and young people, including the educational and voluntary sector.

Although it is beyond the scope of this thesis to discuss in detail, and because the situation remains under intense debate at the time of writing, the place of local GP Commissioning in the development and delivery of services may create new opportunities for primary care based youth mental health services. On the other hand, since adolescent mental health has never enjoyed a high profile nor funding appropriate to the level of need (Richardson et al., 2008), it could also lead to a continuation of the status quo, or even a worsening of the situation, with community based child and adolescent mental health services competing with more established clinical conditions and streams.

As has been demonstrated throughout this thesis, there is a circular direction of influence. Without a prioritizing of adolescent mental health which has to begin with education at the undergraduate level and is then reinforced throughout a GP's professional career, commissioners as practising GPs, are unlikely to recognize the full impact of investing in young people's (mental) health.

Research

If GPs are to be supported in greater engagement with young people presenting with emotional distress they need to have access to a range of strategies which are grounded in rigorous research and demonstrate the value of GP engagement. Robust research needs to underpin what is to be proposed in educational programmes

The f*uture planner approach* offers the most apposite with which to work since it encompasses a structure which facilitates increasing the level of

engagement. This section will identify a number of areas for research which merit further examination. Looking at the applicability of using the HEADSS (McCabe, 1992) screening tool (see Appendix G) in the general practice setting may offer one route. This is a structured framework for conducting a comprehensive biopsychosocial assessment which has recently been expanded to include further categories which reflect the major causes of adolescent morbidity and mortality (HEEADSSS) , (Goldenring and Rosen, 2004) (see Appendix G). A pilot trial of how acceptable and feasible it is to offer a more detailed and comprehensive assessment of emotional distress (when suspected or detected), or a comparison with offering the screening tool to all young people presenting in a given time frame might present as one possible research project.

Remaining within this cognate area, the use of brief behavioural interventions offers further ideas for research in suggesting what might be feasible in practice. Such pilot studies could be targeted at the 'four pillars' of 'sleep; diet; exercise; drug and alcohol use' along with techniques to deal with stress and promote relaxation. Interventions might include techniques such as motivational interviewing (Rollnick et al., 2010) and be informed by the corpus of work undertaken with adult patients around alcohol (Kaner et al., 2007).

*A*t the time of writing a larger cluster randomized trial of a 'screening and motivational interview' intervention for young people presenting in general practice is underway in Melbourne, Australia (Sanci et al, 2011).The findings of this study may offer suggestions in the near future for a UK pilot study to look at the transferability of results across different cultural settings.

Psychological interventions which have been incorporated into the GP's 'tool box' for working with adult patients include the use of (modified) CBT (Wiebe and Greiver, 2005). There is no reason to suppose that modified versions of CBT might not be similarly adapted for use by trained GPs for use with young people. Conducting a trial of (short) CBT in practice also presents itself as a possibility for a research project. Training in additional psychological therapies for GPs referred to Solution Focused Therapy (SFT)

earlier. As with CBT, it may well be feasible to conduct a trial of the use of SFT in general practice.

For those GPs whose style and locus of practice is commensurate with working in the interpretative paradigm, undertaking research in more exploratory areas may be more compelling. Coupled with additional training in therapy modalities such as narrative therapy, GPs working as *collaborators* might engage with research projects which test the applicability of narrative therapy in the consultation.

One new development area which concurs with this paradigm is 'emotional writing' or 'expressive writing' which has been demonstrated to have a positive effect on the physical manifestations of stress such as interrupted sleep and immune system function (Baikie and Wilhelm, 2005). Using the expressive writing technique, participants are asked to write about 'an extremely important emotional issue or event' for 15–20 minutes on three-five occasions each week. Those who do so have been found to have generally significantly better physical and psychological outcomes when compared with those who write about neutral topics (Baike & Wilhelm, 2005). A less structured approach, which might sit more easily within the convention of what Launer terms as 'little-c counselling' (Launer, 1994), might be to suggest keeping a journal. This can be used to make entries at times of stress to see if it is possible to establish patterns of behaviour or triggers at a time of apparent confusion and emotional difficulty in a young person's life.

The examples included thus far have focused on research upon the clinical interaction. Taking a broader perspective, research on the proposed changes in the three domains of education; structural changes and the relationship with CAMHS would all add to a richer understanding of this complex area.

Educational initiatives at a postgraduate level have already been subject to experimentation. Sanci et al (2000) looked at GPs who selected to attend an educational programmes and Bernard et al., (1999) assessed the self-rated performance of GP registrars. There have been no recent research studies

reported in the extant literature which look at educational initiatives at an undergraduate level.

On a wider scale, looking at the implications of structural changes would lend itself to an ethnographic study, with the use of *situational analysis* a useful analytic device. Changing the payment structure for providing 'youth-friendly care' is an experiment in itself (Mangin and Toop, 2007) and there are numerous examples of methodologies which have been used to study the effects of the QOF; a number of which have been presented in this thesis. If the relationships across the primary and secondary care interface are to be interrogated through research, a qualitative approach conducted by an experienced research team, familiar with both worlds and their attendant epistemological frameworks, would be the most appropriate methodology.

The research presented here chose to focus on the GPs' perspective because of the paucity of research and because of the complexity of the field of inquiry. Having completed the research what is now evident is that any subsequent recommendations regarding research must include young people's contributions from the outset (McDonagh and Bateman, 2012). Young people need to be an active participant in the commissioning, designing, and conducting of research and ideally, in the interpretation and dissemination of results.

Policy

This section follows some of the threads mentioned above. If the care of young people with mental health problems is to be improved it will require a reconfiguration of existing service delivery. This may be achieved through commissioning as discussed earlier. However it requires a professional commitment which needs to build upon an ontological and epistemological framework and which acknowledges the value of committing resources to provide an improved integrated provision of care to this group of patients.

This study has demonstrated that the relationship between a local CAMHS team and the GP practices in the locality is critical in enabling or disabling GPs from engaging with young people. Where there was a visible face to

the CAMHS team coupled with reliable telephone access, anxiety levels amongst GPs decreased and their enthusiasm for engaging with young people increased. To link with the recommendation above, a lead GP could make it their priority to make contact with the team by inviting the CAMHS primary mental health worker (PMHW) or equivalent to a practise lunch or practice multi-disciplinary team meeting. The research showed that the value of making contact lay in the demystification of a CAMHS team, otherwise seen as a 'black box' of inexplicable activity, and in being able to put 'a face to a name' thus personalizing the team.

Local changes to clinical behaviour need to be supported by national policy and there needs to be closer working of the respective Royal Colleges of GPs, Psychiatry and Paediatrics and Child Health to advance this agenda.

Promoting improved engagement at a practice level

In the absence of QOF indicators other mechanisms for promoting a change in clinical practice need to be considered. One approach is to consider other (nationally agreed) frameworks and their applicability as 'markers of good practice'. One such template is the 'You're Welcome' criteria. This refers to a series of quality criteria which were developed out of a national initiative, funded and led by the Department of Health, in conjunction with the RCGP Adolescent Task Group. The aim of the project was to encourage practices to work towards the attainment of standards which cover eight areas of practice and organizational culture. These include accessibility; publicity; confidentiality and consent; environment; staff training, skills, attitudes and values; 'joined-up' working; involvement of young people in feedback, monitoring and evaluation; health issues for adolescents. Funding for the process, which formerly resulted in practices being awarded a 'kitemark' of quality, has since been withdrawn by the present government. The criteria, revised in 2011, remain available as a 'self check-list' for practices to judge their youth-friendly performance (Department of Health, 2011).

It may be that linking a performance payment to the fulfilment of the 'You're Welcome' criteria might offer a more constructive approach since it assumes

that promoting widespread engagement in general practice requires a systemic approach.

Conclusion

This study sought to explore the complex clinical area of GPs' views and experiences when consulting with young people experiencing emotional distress. Using an interpretavist methodology, empirical data was gathered and a conceptual framework developed to further our understanding of why some GPs engage with young people and others do not. The conceptual model demonstrates why simply offering additional generic training in adolescent mental health to GPs is unlikely to lead to a change in practice.

The analysis of the empirical data shows how GPs are not homogenous in their approach to clinical situations and a GP's behaviour towards young people presenting in general practice may be understood by looking at their position according to the three pillars which underpin the conceptual model. A GP's performance in the clinical encounter, intertwined with their views of young people, and the perception of their health needs, supported by a preferred epistemological frame of reference, appear pivotal in determining levels of engagement. These translate into a GP's enactment of role which is further influenced by external and structural factors.

Mental ill-health amongst young people is a significant problem and it is unlikely that secondary care will be able to provide all of the resources necessary to deal adequately with young people's needs; nor should the majority of young people in emotional distress be steered towards secondary care. For most this is neither necessary nor preferable.

GPs have considerable expertise in responding to adult mental health problems yet have very limited experience of working therapeutically with young people. Their contribution could be significant and so understanding why GP engagement appears to be at such a low level of activity is important. By producing a conceptual framework to advance our understanding this study offers a way forward to support GPs who wish to deepen their engagement with young people; to support teaching in this

area; to suggest cognate areas for research which will further substantiate the (limited) evidence base and to argue for greater resources to invest in the emotional well-being of young people at a primary care level. McGorry, a leading exponent of youth mental health services in Australia has asserted that 'unmet need is the rule rather than the exception' (McGorry et al., 2007a: S5) and the lack of research in this area has compounded GPs' reluctance to walk in the unchartered waters of adolescent mental health.

The study presented here has intended to shed light on the terrain and to develop a conceptual framework to support greater involvement of GPs to address the unmet and invisible needs of young people.

The genesis of this theoretical framework now allows for the status quo to be challenged and for GPs to move forward with greater clarity and understanding of their role in addressing the emotional needs of young people presenting in general practice.

References

ALCOFF, L. & POTTER, E. (Eds.) (1993) *Feminist Epistemologies,* New York, Routledge.

ALLAN, J. & FONAGY, P. (2006) *Handbook of mentalization-based treatment,* Chichester, John Wiley and Sons, Ltd.

ALLEN, N., HETRICK, S., SIMMONS, J. & HICKIE, I. (2007) Early intervention for depressive disorders in young people: the opportunity and the (lack of) evidence. *Medical Journal of Australia,* 187**,** S15-S17.

AMERICAN PSYCHIATRIC ASSOCIATION (2005) Diagnostic Criteria from DSM-IV-TM (4e) Washington DC, American Psychiatric Association.

ANDREWS, G., SZABO, M. & BURNS, J. (2002) Preventing major depression in young people. *British Journal of Psychiatry,* 181**,** 460-462.

ANGOLD, A., WEISSMANN, M., MERIKANGAS, K., PRUSOFF, P., WICKRAMARATNE, G., GAMMON, G. & WARNER, V. (1987) Parent and child reports of depressive symptoms in children at low and high risk of depression. *J Child Psychol Psychiatry,* 28**,** 901-915.

ARISTOTLE (1973) *The Nichomachean Ethics,* New York, Arno Press.

ARMSTRONG, D. (1979) The emancipation of biographical medicine. *Social Science & Medicine Part a-Medical Sociology,* A13**,** 1-8.

ARMSTRONG, D. (1987) Theoretical tensions in biopsychosocial medicine. *Soc Sci Med,* 25**,** 1213-18.

ARMSTRONG, D. & EARNSHAW, G. (2004) What constructs do GPs use when diagnosing pyschological problems? *Br J Gen Pract,* 54**,** 580-583.

AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE (2003) Australia's young people:their health and well-being. Canberra, AIHW.

BAIKIE, K. A. & WILHELM, K. (2005) Emotional and physical health benefits of expressive writing. *Adv Psychiatr Treat,* 11**,** 338-346.

BALDING, A. & REGIS, D. (2010) Young people into 2010. Exeter, Schools Health Education Unit.

BALINT, M. (1957) *The doctor, the patient, the illness.,* London, Pitman.

BALINT, M. (1961) The pyramid and the psychotherapuetic relationship *Lancet,* 2**,** 1051-54.

BARBOUR, R. & KITZINGER, J. (1999) *Developing focus group research: politics, theory and practice,* London, Sage.

BARLEY, E., MURRAY, J., WALTERS, P. & TYLEE, A. (2011) Managing depression in primary care: A meta-synthesis of qualitative and quantitative research from the UK to identify barriers and facilitators'. *BMC Family Practice,* 12.

BARRY, C. A., STEVENSON, F. A., BRITTEN, N., BARBER, N. & BRADLEY, C. P. (2001) Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. *Social Science & Medicine,* 53**,** 487-505.

BAZERMAN, C. (1994) *Constructing Experience,* Carbondale Southern Illinois University Press.

BELBIN, R. M. (2010) *Team roles at work,* Oxford, Elsevier.

BENDIK, B. & MUNKVOLV, B., E. (2007) The Significance of Member Validation in Qualitative Analysis. *International International Conference on Systems Science* Hawaii.

BERGER, P. & LUCKMAN, T. (1966) *The Social Construction of Reality: a Treatise in the Sociology of Knowledge* Garden City, NJ, Doubleday.

BERNARD, P., GARRALDA, E., HUGHES, T. & TYLEE, A. (1999) Evaluation of a teaching package in adolescent psychiatry for general practice registrars. *Education for Primary Care,* 10**,** 21-28.

BIDDLE, L., DONOVAN, J. L., GUNNELL, D. & SHARP, D. (2006) Young adults' perceptions of GPs as a help source for mental distress: a qualitative study. *Br J Gen Pract,* 56**,** 924-31.

BINDER, P., CARON, C., JOUHET, V., MARCELLI, D. & INGRAND, P. (2010) Adolescents consulting a GP accompanied by a third party: comparative analysis of representations and how they evolve through consultation. *Fam Pract*.

BLUMER, H. (1937) Social Psychology. IN EMERSON, P. (Ed.) *Man and Society: A Substantive Introduction to the Social Science.* New York, Prentice-Hall.

BLUMER, H. (1969a) Society as Symbolic Interaction. IN BLUMER, H. (Ed.) *Symbolic Interaction* Englewood Cliffs,NJ, Prentice-Hall.

BLUMER, H. (1969b) *Symbolic Interaction: Perspective and Method,* Englewood Cliffs, NJ, Prentice-Hall.

BORRELL-CARRIO, F., SUCHMAN, A. L. & EPSTEIN, R. M. (2004) The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Ann Fam Med,* 2**,** 576-582.

BOWER, P., GASK, L., MAY, C. & MEAD, N. (2001) Domains of consultation research in primary care. *Patient Educ Couns,* 45**,** 3-11.

BOWLING, A. (2002) *Research Methods in Health: investigating health and health services,* Maidenhead, Open University Press.

BRENNAN, S. (2012) Cuts to CAMHS services Young Minds.

BRITISH MEDICAL ASSOCIATION (2003) Quality and Outcomes Framework guidance. IN BMA (Ed.). London.

BURY, M. (1982) Chronic illness as biographical disruption. *Sociology of Health & Illness,* 4**,** 167-182.

BUSHNELL, J., MCLEOD, D., DOWELL, A., SALMOND, C., RAMAGE, S., COLLINGS, S., ELLIS, P., KLJAKOVIC, M. & MCBAIN, L. (2005) Do patients want to disclose psychological problems to GPs? *Fam Pract,* 22**,** 631-7.

BYCZKOWSKI, T. L., KOLLAR, L. M. & BRITTO, M. T. (2010) Family experiences with outpatient care: do adolescents and parents have the same perceptions? *J Adolesc Health,* 47**,** 92-8.

CAHILL, P. & PAPAGEORGIOU, A. (2007) Triadic communication in the primary care paediatric consultation: a review of the literature. *Br J Gen Pract,* 57**,** 904-11.

CAMPBELL, S. & LESTER, H. (2010) Developing QOF indicators and the concept of Qofability. *The Quality and Outcomes Framework: transforming general practice.* Oxford, Radcliffe Publishing.

CAMPBELL, S., REEVES, D., KONTOPANTELIS, E, , MIDDLETON, E., SIBBALD, B. & ROLAND, M. (2007) Improvements in clinical quality in English primary care before and after the introduction of a pay for performance scheme: longitudinal study. *New England Journal of Medicine,* 357**,** 181-90.

CAPE, J., BARKER, C., BUSZEWICZ, M. & PISTRANG, N. (2000a) General Practitioner psychological management of common emotional problems (I):definitons and literature review. *Br J Gen Pract,* 50**,** 313-318.

CAPE, J., BARKER, C., BUSZEWICZ, M. & PISTRANG, N. (2000b) General practitioner psychological management of common emotional problems (II): A research agenda for the development of evidence-based practice. *Br J Gen Pract,* 50**,** 396-400.

CARR, W. (1986) Theories of Theory and Practice. *Journal of Philosophy of Education* 20**,** 177-186.

CASSELL, E. (1982) The nature of suffering and the goals of medicine. *NEJM,* 306**,** 639-645.

CHARLES-JONES, H., LATIMER, J. & MAY, C. (2003) Transforming general practice: the redistribution of medical work in primary care. *Sociology of Health & Illness,* 25**,** 71-92.

CHARMAZ, K. (2006) *Constructing Grounded Theory: A practical guide through qualitative analysis,* Thousand Oaks, California, Sage Publications, Inc.

CHECKLAND, K., HARRISON, S., MCDONALD, R., GRANT, S., CAMPBELL, S. & GUTHRIE, B. (2008) Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner contract. *Sociology of Health & Illness,* 30**,** 788-803.

CHEETHAM, M. (2010) Young people and sexual health: exploring the social meanings of a C-Card condom distribution scheme *School of Geography, Politics and Sociology.* Newcastle University.

CHEW-GRAHAM, C., MAY C, COLE, H. & HEDLEY, S. (2000) The burden of depression in primary care:a qualitative investigation of general practitioners' constructs of depressed people in the inner city. *Primary Care Pyschiatry,* 6**,** 137-141.

CHOWN, P., KANG, M., SANCI, L., NEWNHAM, V. & BENNETT, D. (2008) *Adolescent Health: Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds.GP Resource kit.,* Sydney, NSW Centre for the Advancement of Adolescent Health and Transcultural Mental Health Centre.

CHURCHILL, R. (2008) Child and Adolescent Mental Health. IN COHEN, A. (Ed.) *Delivering mental health for primary care: an evidence based approach.* London, RCGP.

CHURCHILL, R., ALLEN, J., DENMAN, S., WILLIAMS, D., FIELDING, K. & VON FRAGSTEIN, M. (2000) Do the attitudes and beliefs of young teenagers towards general practice influence actual consultation behaviour? *Br J Gen Pract,* 50**,** 953-7.

CLARKE, A. (2005) *Situational analysis: Grounded Theory after the postmodern turn. Sage Publications, Inc,* Thousand Oaks, California, Sage Publications, Inc.

COCKBURN, K. & BERNARD, P. (2004) Child and adolescent mental health within primary care : a study of general practioner's perceptions. *Child and Adolescent Mental Health,* 9**,** 21-24.

COCKSEDGE, S., GREENFIELD, R., NUGENT, G. K. & CHEW-GRAHAM, C. (2011) Holding relationships in primary care: a qualitative exploration of doctors' and patients' perceptions. *Br J of Gen Pract,* 61**,** e484-e491.

COCKSEDGE, S. & MAY, C. (2005) Pastoral relationships and holding work in primary care: affect, subjectivity and chronicity. *Chronic Illn,* 1**,** 157-63.

COLEMAN, J. (2011) Adolescent health in the UK today: where next ? London, Association of Young People's Health.

COLEMAN, J., BROOKS, F. & TREADGOLD, P. (2011) Key Data on Adolescence London, Association for Young People's Health.

CORBIN, J. (1998) Alternative interpretations-Valid or not? *Theory and Psychology,* 8**,** 121-8.

CORBIN, J. & STRAUSS, A. (2008) *Basics of Qualitative Research: Techniques and Procedures for developing grounded theory,* Thousand Oaks, California, Sage Publications, Inc.

COYLE, J., PINE, D. & CHARNEY, D. (2003) Depression and bipolar support alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry,* 42**,** 1494-1503.

CRESWELL, J. (1998) *Qualitative inquiry and research design:Choosing among five traditions,* Thousand Oaks,CA, Sage.

DAVIDSEN, A. S. (2009) How does the general practitioner understand the patient? A qualitative study about psychological interventions in general practice. *Psychol Psychother,* 82**,** 199-217.

DENZIN, N. (2004) Symbolic Interactionism. IN FLICK, U., KARDOFF, E, STEINKE, I. (Ed.) *A companion to qualitative research.* London, Sage Publications.

DENZIN, N., K. (1989) *The Research Act: A Theoretical Introduction to Sociological Methods,* Englewood Cliffs,NJ, Prentice Hall.

DENZIN, N. & LINCOLN, Y. (Eds.) (2003) *The Handbook of Qualitative Research,* Thousand Oaks, California, Sage Publications, Inc.

DENZIN, N. & LINCOLN, Y. (2008) *The landscape of qualitative research,* California, Sage Publications, Inc.

DENZIN NK & LINCOLN, Y. (Eds.) (2003) *The Handbook of Qualitative Research,* Thousand Oaks, California, Sage Publications, Inc.

DEPARTMENT FOR EDUCATION AND SKILLS (2002) Every Child Matters: change for children London, HMSO.

DEPARTMENT OF HEALTH (2004a) *Child and Adolescent Mental Health-National Service Framework for Children, Young People and Maternity Services* London, Department of Health

DEPARTMENT OF HEALTH (2004b) The National Health Service (General Medical Services Contracts) Regulations 2004. London, The National Archives.

DEPARTMENT OF HEALTH (2009) The healthy child programme. London, The Stationery Office.

DEPARTMENT OF HEALTH (2010a) Adolescent Health. London, Department of Health.

DEPARTMENT OF HEALTH (2010b) Early intervention : Securing good outcomes for all children and young people. IN DEPARTMENT OF CHILDREN SCHOOLS AND FAMILIES (Ed.). London, The Stationery Office.

DEPARTMENT OF HEALTH (2011) 'You're Welcome': quality criteria for young people friendly health services. London, Department of Health.

DEWEY, J. (1938) *Experience and Education,* New York, Collier Books.

DEY, I. (1999) *Grounding Grounded Theory,* San Diego, Academic Press.

DOWRICK, C. (2009a) *Beyond Depression: a new approach to understanding and management,* Oxford, Oxford University Press.

DOWRICK, C. (2009b) Reasons to be cheerful ? Reflections on GPs' responses to depression. *Br J Gen Pract,* 59**,** 636-7.

DOWRICK, C., LEYDON, G., M,, MCBRIDE, A., HOWE, A., BURGESS, H., CLARKE, P., MAISEY, S. & KENDRICK, T. (2009) Patients' and doctors' views on depression severity questionnaires incentivised in UK quality and outcomes framework: qualitative study. *BMJ,* 338**,** b663.

DOWRICK, C., MAY, C., RICHARDSON, M. & BUNDRED, P. (1996) The biopsychosocial model of general practice: rhetoric or reality? *Br J Gen Pract,* 46**,** 105-7.

DREYFUS, H. & RABINOW, P. (1982) *Michel Foucault: Beyond Structuralism and Hermenuetics* Chicago University of Chicago Press.

ENGEL, G. (1977) The need for a new medical model: a challenge for biomedicine. *Science,* 196**,** 129-36.

EPSTEIN, R. M. (1999) Mindful practice. *Jama-Journal of the American Medical Association,* 282**,** 833-839.

FERRIN, M., GLEDHILL, J., KRAMER, T. & ELENA GARRALDA, M. (2009) Factors influencing primary care attendance in adolescents with high levels of depressive symptoms. *Soc Psychiatry Psychiatr Epidemiol,* 44**,** 825-33.

FITZPATRICK, B., GOURLAY, G., MCCONNACHIE, A., MERCER, S., VOJT, G. & WATT, G. (2007) More time for complex consultations in a high deprivation practice is associated with increased patient enablement. *Br J Gen Pract,* 57**,** 960-966.

FLICK, U. (2002) *An introduction to qualitative research,* London, Sage.

FONAGY, P. (1991) Thinking about thinking:some clincial and theoretical considerations in the treatment of a borderline patient. *International Journal of Psychoanalysis,* 72**,** 639-656.

FONAGY, P., GERGELY, G., JURIST, E. & TARGET, M. (2002) *Affect regulation, mentalization and the development of self,* New York, Other Press.

FORD, C. A., BEARMAN, P. S. & MOODY, J. (1999) Foregone health care among adolescents. *JAMA,* 282**,** 2227-34.

FOUCAULT, M. (1961) *History of Madness,* New York, Routledge.

FOUCAULT, M. (1963) *Naissance de la clinique,* New York, Random House.

FOUCAULT, M. (1966) *The Order of Things,* New York, Routledge.

FOUCAULT, M. (1975a) *The Birth of the Clinic: an Archeology of Medical Perception,* New York, Random House

FOUCAULT, M. (1975b) *Discipline and Punish: The birth of the prison,* New York, Random House.

FOUCAULT, M. (1991) Questions of Method. IN BURCHELL, G., GORDON, C. & MILLER, P. (Eds.) *The Foucault Effect: Studies in Governmetality.* Chicago, University of Chiacago Press.

FOX, R. (2002) Medical Uncertainty revisited IN BENDELOW G, CARPENTER M, VANTIER C & WILLIAMS S (Eds.) *Gender,health and healing.* London, Routledge.

GEERTZ, C. (1973) *The Interpretation of Cultures,* New York, Basic Books.

GENEAU, R., LEHOUX, P., PINEAULT, R. & LAMARCHE, P. (2008) Understanding the work of general practitioners: a social science perspective on the context of medical decision making in primary care. *BMC Family Practice,* 9.

GERMER, C. & SIEGLE, R. (Eds.) (2012) *Wisdom and Compassion in Psychotherapy: Deepening Mindfulness in Clinical Practice.,* New York, The Guildford Press.

GIDDENS, A. (1984) *The constitution of society,* Berkeley, University of California Press.

GILBERT, P. (2009) *The Compassionate Mind: Coping with the Challenges of Living. ,* London, Constable Robinson.

GLASER, B. (1978) *Theoretical Sensitivity,* Mill Valley, CA, The Sociology Press.

GLASER, B. (1992) *Basics of grounded theory analysis,* Mill Valley,CA, The Sociology Press.

GLASER, B. & STRAUSS, A. (1967) *The discovery of grounded theory,* Chicago, Aldine.

GLEDHILL, J. & GARRALDA, M. (2011) The short-term outcome of depressive disorder in adolescents attending primary care: a cohort study. *Soc Psychiatry Psychiatr Epidemiol,* 46**,** 993-1002.

GLEDHILL, J., KRAMER, T., ILIFFE, S. & GARRALDA, M. (2003) Training general practitioners in the identification and management of adolescent depression within the consultation: a feasibility study. *Journal of Adolescence,* 26**,** 245-250.

GOFFMAN, E. (1963) *Stigma: notes on the management of spoiled identity,* New York, Simon & Schuster.

GOGTAY, N., GIEDD, J., LUSK, L., HAYASHI, K., GREENSTEIN, D. & AL., V. A. E. (2004) Dynamic mapping of human cortical development during childhood through early adulthood. *Proc Natl Acad Sci USA,* 101**,** 8174–8179.

GOLDBERG, D. & HUXLEY, P. (1992) *Common mental disorders:a bio-social model,* London, Routledge.

GOLDENRING, J. & ROSEN, D. (2004) Getting into adolescent heads:An essential update. *Contemporary Pediatrics,* 21**,** 64-90.

GOODMAN, R., FORD, T. & MELTZER, H. (2002) Mental health problems of children in the community: 18 month follow up. *BMJ,* 324**,** 1496-7.

GOODYER, I. & COOPER, P. (1993) A community study of depression in adolescent girls. II : the clinical features of identified disorder. *Brit J Psychiatry,* 163**,** 374-380.

GOODYER, I., HERBERT, J. & TAMPLIN, A. (2003) Psychoendocrine antecedents of persistent first-episode major depression in adolescents:a community based longitudinal enquiry. *Psychological Medicine,* 33**,** 601-610.

GOULD, M., VELTING, D., KLEINMAN, M. & ET AL (2004) Teenagers' attitudes about coping strategies and help-seeking behaviour for suicidality. *J Am Acad Child Adolesc Psychiatry,* 43**,** 1124-33.

GREENHALGH, T. & HURWITZ, B. (Eds.) (1998) *Narrative Based Medicine: Dialogue and discourse in clinical practice,* London, BMJ Books.

GRIFFITHS, F. & BYRNE, D. (1998) General practice and the new science emerging from the theories of 'chaos' and complexity. *B J Gen Pract,* 48**,** 1697-1699.

GUBA, E. (1990) The alternative paradigm dialogue. IN GUBA, E. (Ed.) *The paradigm dialog.* Newbury Park,CA, Sage.

GUBA, E. & LINCOLN, Y. (1981) *Effective evaluation: improving the usefulness of evaluation results through responsive and naturalistic responses,* San Francisco, Jossey-Bass.

HACKING, J. M., MULLER, S. & BUCHAN, I. E. (2011) Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study. *BMJ,* 342.

HAFFERTY, F. W. & FRANKS, R. (1994) The hidden curriculum, ethics teaching, and the structure of medical education. *Acad Med,* 69**,** 861-871.

HAFTING, M. & GARLOV, I. (2009) "You may wade through them without seeing them": General practitioners and their young patients with mental health problems. *Nord J Psychiatry,* 63**,** 256-9.

HALLER, D., SANCI, L., SAWYER, S. & PATTON, G. (2009) The identification of young people's emotional distress: a study in primary care. *Br J Gen Pract,* 59**,** e61-70.

HARAWAY, D. (1991) Situated Knowledges:The Science Question in Feminism and the Privilege of Partial Perspective. IN HARAWAY, D. (Ed.) *Simians, Cyborgs and Women: The Reinvention of Nature* New York, Routledge.

HARRINGTON, A. (2012) The fall of the schizophrenogenic mother. *Lancet,* 379**,** 1292-3.

HAWTON, K., SAUNDERS, K. E. & O'CONNOR, R. C. (2012) Self-harm and suicide in adolescents. *Lancet,* 379**,** 2373-82.

HEATH, I. (1999) Uncertain clarity: contradiction, meaning, and hope. *Brit J Gen Pract,* 49**,** 651-657.

HEATH, I. (2011) Divided we fail: The Harveian Oration 2011. *Harveian Oration.* London, Royal College of Physicians

HEATH, I., HIPPERSLEY-COX, J, & SMEETH, L (2007) Measuring performance and missing the point ? *BMJ,* 335**,** 1075-6.

HEATH, I., RUBINSTEIN, A., STANGE, K. C. & VAN DRIEL, M. L. (2009) Quality in primary health care: a multidimensional approach to complexity. *BMJ,* 338**,** 911-13.

HERBERT, J., GOODYER, I. & ALTHAM, P. (1996) Adrenal secretion and major depression in 8-16 year olds.II. Influence of co-morbidity at presentation *Psychological Medicine,* 26**,** 257-263.

HEYLAND, S. (2012) The therapeutic alliance. *Br J Psychiatry,* 200**,** 355.

HICKIE, I., FOGARTY, A., DAVENPORT, T., LUSCOMBE, G. & BURNS, J. (2007) Responding to experiences of young people with common mental health problems attending Australian general practice. *Medical Journal of Australia,* 187**,** S47-S52.

HIPPERSLEY-COX, J. & VINOGRADOVA, Y. (2009) Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the

QResearch® database:Final Report to the NHS Information Centre and Department of Health. Nottingham, The Health and Social Care Information Centre.

HOLMES, J. (2000) Psychotherapy and general practice: Evidence, narrative and the 'New Deal' in mental health. *Psychoanalytical Psychotherapy,* 14**,** 129-141.

HORDER, J., BYRNE, P., FREELING, P., HARRIS, C., IRVINE, D. & MARINKER, M. (1972) The Future General Practitioner. London, The Royal College of General Practitioners

HOWIE, J., HEANEY, D, MAXWELL, M. (2004) Quality, core values and the general practice consultation: issues of definition,measurement and delivery. *Family Practice,* 21**,** 458-68.

HUDSON, L. D., STEPHENSON, T., CHRISTIE, D. & VINER, R. (2011) Putting young people's behaviour in perspective. *BMJ,* 343.

HUGHES, E. (1971) *The Sociological Eye,* Chicago, Aldine Atherton.

ILLICH I (1974) Medical nemesis. *Lancet,* 303**,** 918-921.

ILLIFFE, S., GALLANT, C., KRAMER, T., GLEDHILL, J., BYE, A., FERNANDEZ, V., VILA, M., MILLER, L. & GARRALDA, M. (2012) Therapeutic identification of depression in

young people: lessons from the introduction of a new technique in general practice. *Br J Gen Pract,* 62**,** 134-135.

ILLIFFE, S., WILLIAMS, G., FERNANDEZ, V., VILA, M., KRAMER, T., GLEDHILL, J. & MILLER, L. (2008) General Practitioners' understanding of depression in young people:qualitative study. *Primary Health Care Research and Development,* 9**,** 269-279.

INSEL, T. & FENTON, W. (2005) Psychiatric epidemiology: It's not just about counting anymore *Arch Gen Psychiatry* 62**,** 590-592.

JACOBSON, L., CHURCHILL, R., DONOVAN, C., GARRALDA, E. & FAY, J. (2002) Tackling teenage turmoil: primary care recognition and management of mental ill health during adolescence. *Fam Pract,* 19**,** 401-9.

JACOBSON, L. D., WILKINSON, C. & OWEN, P. A. (1994) Is the potential of teenage consultations being missed?: a study of consultation times in primary care. *Fam Pract,* 11**,** 296-9.

JAMES, A. & PROUT, C. (Eds.) (1997) *Constructing and Reconstructing Childhood: contemporary issues in the sociology of childhood,* London, Routledge Farmer.

JENKINS, R., MCCULLOCH, A., FRIEDLI, L. & PARKER, C. (2002) *Developing a National Health Policy,* Hove, The Psychology Press.

JOAS, H. (1985) *GH Mead: A contemporary re-examination of his thought,* Cambridge, Mass., MIT Press.

JONES, D. (2011) Consultation skills and the work of Michael Balint. *InnovAIT,* 4**,** 658-662.

JONES, L. & GREEN, J. (2006) Shifting discourses of professionalism: a case study of general practitioners in the United Kingdom. *Sociol Health Illn,* 28**,** 927-50.

KANER, E., DICKINSON, H., BEYER, F., CAMPBELL, F., SCHLESINGER, C., HEATHER, N., SAUNDERS, J., BURNAND, B. & PIENAAR, E. (2007) Effectiveness of alcohol interventions in primary care populations (Review). *The Cochrane Collaboration.* Cochrane Data base of Systematic Reviews.

KAPFERER, B. (1997) Agency or human agency. IN BARFIELD, T. (Ed.) *The Dictionary of Anthropology.* 1st ed. Oxford, Blackwell Publishing.

KARASZ, A., DOWRICK, C., BYNG, R., BUSZEWICZ, M., FERRI, L., HARTMAN, T. C. O., VAN DULMEN, S., VAN WEEL-BAUMGARTEN, E. & REEVE, J. (2012) What we talk about when we talk about depression: doctor-patient conversations and treatment decision outcomes. *BrJ Gen Pract,* 62**,** e55-e63.

KATZ, A. M. & ALEGRÍA, M. (2009) The clinical encounter as local moral world: Shifts of assumptions and transformation in relational context. *Social Science & Medicine,* 68**,** 1238-1246.

KENDRICK, T., DOWRICK, C., MCBRIDE, A., HOWE, A., CLARKE, P., MAISEY, S., MOORE, M. & SMITH, P., W. (2009) Management of depression in UK general practice in relation to scores on depression severity questionnaires: analysis of medical record data. *BMJ,* 338**,** b750.

KENNEDY, I. (2010) Getting it right for children and young people:overcoming cultural barriers in the NHS so as to meet their needs. A review by Sir Ian Kennedy. London, Department of Health.

KESSLER, R., BERGLUND, P., DEMLER, O., JIN, R., MERIKANGAS, K. & WALTERS, E. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry,* 62**,** 593-602.

KIRKENGEN, A. L. (2010) *The Lived Experience of Violation: How abused children become Unhealthy Adults* Bucharest, Zeta Books.

KLEINMAN, A. (1999) Moral experience and ethical reflection:can ethnography reconcile them? A quandry for 'the new bioethics'. *Bioethics and beyond,* 128**,** 69-97.

KLEINMAN, A., EISENBERG, L. & GOOD, B. (1978) Culture, illness, and care. Clinical lessons from anthroplogical and cross-cultural research. *Annals of Internal Medicine,* 88**,** 251-8.

KOIVUSILTA, L., RIMPELA, A. & RIMPELA, M. (1999) Health-related lifestyle in adolescence - origin of social class differences in health? *Health Educ Res,* 14**,** 339-55.

KOLB, D. (1984) *Experiential learning: experience as the source of learning and development,* Englewood Cliffs, NJ, Prentice Hall.

KRAMER, G. (2012) Payment for Performance and the QOF: are we doing the right thing? *Br J Gen Pract,* 62**,** e217-e219.

KRAMER, T. & GARRALDA, M. (1998) Psychiatric disorders in adolescents in primary care *Brit J Psychiatry,* 173**,** 508-513.

KRAMER, T. & GARRALDA, M. (2000) Child and adolescent mental health problems in primary care. *Advances in Psychiatric Treatment,* 6**,** 287-294.

KUHN, T. (1962) *The structure of scientifc revolutions,* Chicago, University of Chicago.

KUPER, A., REEVES, S. & LEVINSON, W. (2008) An introduction to reading and appraising qualitative research. *BMJ,* 337**,** 337-407.

LAKHANI, M., BAKER, M. & FIELD, S. (2007) The Future Direction of General Practice: a roadmap. London, The Royal College of General Practitioners.

LAMB, S. & POYNTON, J. (2012) Understanding the health needs and experiences of young people: Evidence from a Young Person's Clinic in London. *Improving young people's health and wellbeing-Research into Practice.* Cardiff, AYPH.

LARGE, P. & GHOSH, K. (2006) Estimates of the population by ethnic group for areas within England. London, National Statistic Centre for Demography Office for National Statistics.

LAUNER, J. (1994) Psychotherapy in the general practice surgery:working with and without a secure therapeutic frame. *British Journal of Psychotherapy,* 11**,** 120-126.

LAUNER, J. (2002) *Narrative Based Primary Care: a practical guide,* Oxford, Radcliffe Medical Press.

LAYARD, R. & DUNN, J. (2009) A good childhood.Searching for values in a competitive age. London, Children's Society.

LEMPP, H. & SEALE, C. (2004) The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. *BMJ,* 329**,** 770-3.

LESTER, H., CAMPBELL,S MCDONALD, R (2009) The present state and future direction of primay care: a qualitative study of GPs views. *Br J Gen Pract,* 59**,** 908-915.

LINCOLN, Y. (2004) Norman K. Denzin: A life in transit IN FLICK UV, K. E., STEINKE I. (Ed.) *A companion to qualitative research* London, Sage Publications.

LINGARD, L., ALBERT,M, LEVINSON,W. (2008) Grounded theory,mixed methods, and action research. *BMJ,* 337.

LYKKE, K., CHRISTENSEN, P. & REVENTLOW, S. (2011) The consultation as an interpretive dialogue about the child's health needs. *Fam Pract,* 28**,** 430-6.

MACFARLANE, A. & MCPHERSON, A. (1995) Primary health care and adolescence. *BMJ,* 311**,** 825-6.

MANGIN, D. & TOOP, L. (2007) The Quality and Outcomes Framework: what have you done to yourselves? *Br J Gen Pract,* 57**,** 435–437

MARMOT, M. (2008) Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health IN MARMOT M (Ed.). Geneva, World Health Organization.

MARMOT, M. (2010) Fair society, healthy lives. IN MARMOT, M. (Ed.). London, University College London.

MARSHALL, M., ROLAND, M. (2002) The new contract: renaissance or requiem for general practice? *Br J Gen Pract,* 52**,** 531-2.

MARTINEZ, R., REYNOLDS, S. & HOWE, A. (2006) Factors that influence the detection of psychological problems in adolescents attending general practices. *Br J Gen Pract,* 56**,** 594-9.

MAUERHOFER, A., BERCHTOLD, A., MICHAUD, P. A. & SURIS, J. C. (2009) GPs' role in the detection of psychological problems of young people: a population-based study. *Br J Gen Pract,* 59**,** e308-14.

MAY, C., MEAD,N, (1999) *Patient-centredness: a history.,* London, Routledge.

MAY, T. (2006) *The Philosophy of Foucault,* Chesham, Bucks, Acumen.

MCCABE, R. (1992) Psychiatric disturbance. *Practitioner,* 236**,** 1150-54.

MCCARTHY, D. (1996) *Knowledge as culture: the new sociology of knowledge,* New York, Routledge.

MCDONAGH, J. & BATEMAN, B. (2012) 'Nothing about us without us': considerations for research involving young people. *Arch Dis Child Educ Pract Ed,* 97**,** 55-60.

MCDONALD, R., HARRISON, S., CHECKLAND, K., CAMPBELL, S. M. & ROLAND, M. (2007a) Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study. *BMJ,* 334**,** 1357-.

MCDONALD, R., HARRISON, S., CHECKLAND, K., CAMPBELL, S. M. & ROLAND, M. (2007b) Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study. *British Medical Journal,* 334**,** 1357-1359.

MCGORRY, P. (2007) The specialist youth mental health model: strengthening the weakest link in the public mental health system *Medical Journal Australia,* 187**,** S53-S56.

MCGORRY, P., PURCELL, R., HICKIE, I. & JORM, A. (2007a) Investing in youth mental health is a best buy. *Medical Journal of Australia,* 187**,** S5-S7.

MCGORRY, P., PURCELL, R., HICKIE, I., YUNG AR, PANTELIS, C. & JACKSON, H. (2007b) Clinical staging: a heuristic model for psychiatry and youth mental health. *Medical Journal of Australia,* 187**,** S40-S42.

MCKELVEY, R., PFAFF , J. & ACRES, J. (2001) The relationship between chief complaints, psychological distress, and suicidal ideation in 15-24-year-old patients presenting to general practitioners. *Med J Aust,* 175**,** 550-2.

MCWHINNEY, I. (2000) Being a general practitioner: what it means. *Eur J Gen Pract,* 6**,** 135-139.

MENTAL HEALTH FOUNDATION (2007) Listen up! Person-centred approaches to help young people experiencing mental health and emotional problems. London, Mental Health Foundation.

MERCER, S. & REYNOLDS, W. (2002) Empathy and quality of care. *Brit J Gen Pract,* 52**,** S9-S13.

MERCER, S., W, & WATT, G. (2007) The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. Annals of Family Medicine. *Annals of Family Medicine,* 5**,** 503-10.

MICHAUD, P. & FOMBONNE, E. (2005) Common mental health problems. *BMJ,* 330**,** 835-838.

MITCHELL, C., DWYER, R., HAGAN, T. & MATHERS, N. (2011) Impact of the QOF and the NICE guideline in the diagnosis and management of depression: a qualitative study. *Br J Gen Pract,* 11**,** e279-e289.

MITCHELL, J., MCCAULEY, E., BURKE, P. & ET AL (1988) Phenomenology of depression in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* 27**,** 12-20.

MITCHELL, S. (1999) Attachment theory and the psychoanalytical tradition: Reflections on human relationality. *Psychoanalytical dialogues,* 9**,** 86-107.

MORSE, J., ANDERSON, G., BOTTER, J. & AL., E. (1992) Exploring empathy: a conceptual fit for nursing practice. *Image J Nurs Sch,* 24**,** 273-280.

MOSCROP, A. (2011) 'Heartsink' patients in general practice: a defining paper, its impact and psychodynamic potential. *Br J Gen Pract,* 61**,** 346-348.

NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE (2004) Eating Disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. London, NICE.

NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE (2005) Depression in children and young people: identfication and management in primary, community and secondary care. *National Clinical Practice Guidelines.* London, NICE.

NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE (2008) Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children,young people and adults. Clinical guideline CG 72. London, NICE.

NORTH EAST PUBLIC HEALTH OBSERVATORY (2006) Black and Ethnic Minorities. http://www.nepho.org.uk/topics/BlackandEthnicMinorities.

O'CONNELL, B. (2005) *Solution Focused Therapy,* London, Sage Publications.

O'DOWD, T. (1988) Five years of heartsink patients in general practice. *BMJ,* 297**,** 528-530.

OFFICE FOR NATIONAL STATISTICS (2005) Mental health in children and young people in Great Britain, 2004. London, HMSO.

OFFICE FOR NATIONAL STATISTICS (2008) *General Household Survey 2005*. London, Office for National Statistics.

OKSALA, J. (2007) *How to read Foucault,* New York, Norton & Company.

PATEL, V., FLISHER, A., HETRICK, S. & MCGORRY, P. (2007) Mental health of young people: a global public-health challenge. *Lancet,* 369**,** 1302-13.

PATTON, M. (2002) *Qualitative research and evaluation methods* Newbury Park,CA, Sage.

POOL, R. & GEISSLER, W. (2005) *Medical Anthroplogy,* Maidenhead, Open University Press and London School of Tropical Medicine.

PRIOR, L., WOOD, F., LEWIS, G. & PILL, R. (2003) Stigma revisited, disclosure of emotional problems in primary care consultations in Wales. *Soc Sci Med,* 56**,** 2191-2200.

RAINE, R., LEWIS, L., SENSKY, T., HUTCHINGS, A., HIRSCH, S. & BLACK, N. (2000) Patient determinants of mental health interventions in primary care. *Br J Gen Pract,* 50**,** 620-5.

RAPOPORT, J. & GOGTAY, N. (2008) Brain Neuroplasticity in Healthy, Hyperactive and Psychotic Children: Insights from Neuroimaging. *Neuropsychopharmacology,* 33**,** 181-197.

RAWLINSON, M. (2011) The relationship between NICE and young people. IN THE RCGP ANNUAL PRIMARY CARE CONFERENCE (Ed.). Liverpool.

REEVE, J. (2009) Interpretative Medicine. *Occas Pap R Coll Gen Pract,* 88.

REEVE, J., LLOYD-WILLIAMS, M., PAYNE, S. & DOWRICK , C. (2010) Revisiting biographical disruption: exploring individual embodied experience in people with terminal cancer. *Health,* 14**,** 1-18.

REEVE, J., LYNCH, T., LLOYD-WILLIAMS, M. & PAYNE, S. (2011) From personal challenge to technical fix: the risks of depersonalised care. *Health Soc Care Community*.

REINHARZ, S. (1997) Who am I ? The need for a variety of selves. IN HERTZ.R. (Ed.) *Reflexivity and Voice.* Thousand Oaks, CA, Sage.

RICHARDSON, G., KELVIN, R. & GOWERS, S. (2008) The National CAMHS review : A response from the Royal College of Psychiatrists
Child and Adolescent Faculty. London, Royal College of Psychiatry.

RICKWOOD, D., DEANE, F. & WILSON, C. (2007) When and how do young people seek professional help for mental health problems? *Medical Journal of Australia,* 187**,** S35-S39.

RIDD, M., LEWIS, G., PETERS, S. & SALISBURY, C. (2012) Detection of patient psychological distress and longitudinal patient-doctor relationships: a cross-sectional study. *Br J Gen Pract,* 62**,** e167-173.

RITZER, G. & GOODMAN , D. (2003) *Sociological Theory,* New York, McGraw-Hill.

ROBERTS, J. H. (2009) Structural violence and emotional health: a message from Easington, a former mining community in Northern England *Anthropology and Medicine* 16**,** 37-48.

ROBERTS, J. H. (2012) Improving primary health care services for young people experiencing psychological distress and mental health problems: a personal reflection on lessons learnt from Australia and England. *Primary Research Care and Development,* 13**,** in press.

ROBERTS, J. H. & BARNARD, P. (2012) "Can he have the test for bipolar, doctor? His dad's got it." Exploring the potential of General Practitioners to work with children and young people presenting in primary care with common mental health problems: a clinical initiative. *Mental Health in Family Medicine,* 8**,** in press.

ROCK, P. (1979) *The Making of Symbolic Interactionism,* Totowa, NJ., Rowman & Littlefield.

ROLLNICK, S., BUTLER, C. C., KINNERSLEY, P., GREGORY, J. & MASH, B. (2010) Motivational interviewing. *BMJ,* 340**,** c1900.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (2010) RCGP Child Health Strategy London, RCGP.

RUTTER, M. & TAYLOR, E. (2002) *Child and Adolescent Psychiatry,* Oxford, Blackwell Science.

SACKETT, D. L., ROSENBERG, W. M. C., GRAY, J. A. M., HAYNES, R. B. & RICHARDSON, W. S. (1996) Evidence based medicine: what it is and what it isn't. *BMJ,* 312**,** 71-72.

SANCI, L., COFFEY, C., VEIT, F., CARR-GREGG, M., PATTON, G., DAY, N. & BOWES, G. (2000) Evaluation of the effectiveness of an educational intervention for general practitioners in adolescent health care: randomised controlled trial *BMJ,* 320**,** 224-230.

SANCI L, P. G., SHIELL A, PIRKIS J, SAWYER S, HEGARTY K, CHONDROS P, GRABSCH B, YANG F. (2011) Screening and counselling young people for health risks in general practice: a stratified cluster randomised trial. *Primary Health Care Research Conference. .* Brisbane, Australia.

SAWYER, S. M., AFIFI, R. A., BEARINGER, L. H., BLAKEMORE, S. J., DICK, B., EZEH, A. C. & PATTON, G. C. (2012) Adolescence: a foundation for future health. *Lancet,* 379**,** 1630-40.

SAYAL, K. & TAYLOR, E. (2004) Detection of child mental health disorders. *Br J Gen Pract,* 54**,** 348-352.

SAYAL, K., TISCHLER, V., COOPE, C., ROBOTHAM, S., ASHWORTH, M., DAY, C., TYLEE, A. & SIMONOFF, E. (2010) Parental help-seeking in primary care for child and adolescent mental health concerns: qualitative study. *Br J Psychiatry,* 197**,** 476-81.

SCHOFIELD, P., CROSLAND, A., WAHEED, W., ASEEM, S., GASK, L., WALLACE, A., DICKENS, A. & TYLEE, A. (2011) Patients' views of antidepressants: from first experiences to becoming expert. *British Journal of General Practice,* 61**,** e142-e148.

SCHON, D. (1983) *The reflective practitioner,* San Francisco, Jossey-Bass.

SCHUTZ, A. (1967) *The Phenomenology of the Social World,* Evanston,Ill., Northwestern University Press.

SHEKELLE, P. (2003) New contract for general practitioners. *BMJ,* 326**,** 457-8.

SIEGEL, Z., WILLIAMS, M. & TEASDALE, J. (Eds.) (2002) *Mindfulness-based Cognitive Therapy for Depression: a new approach to preventing relapse,* New York, Guildford Press.

SILVERMAN, J. & KINNERSLEY, P. (2012) Calling time on the 10-minute consultation. *Brit J Gen Pract,* 62**,** 1118-9.

SINCLAIR, S. (1997) *Making doctors:An institutional apprenticeship (explorations in anthropology),* London, Berg Publishers.

SINGLETON, N., BUMPSTEAD, R., O'BRIEN, M., LEE, A. & MELTZER, H. (2001) Psychiatric morbidity in adults living in private households, 2000. Norwich, The Stationery Office.

STEEL, N., MAISEY, S., CLARK, A., FLEETCROFT, R. & HOWE, A. (2007) Quality of clinical primary care and targeted incentive payments: an observational study. *Br J Gen Pract,* 57**,** 449–454.

STRAUSS, A. (1987) *Qualitative analysis for social scientists,* New York, Cambridge University Press.

TAIT, L. (2009) To disclose or not to disclose psychological problems to GPs. *Br J Gen Pract,* 59**,** 638-9.

THE CHILDREN AND YOUNG PEOPLE'S IAPT PROJECT (2012).
*http://www.**iapt**.nhs.uk/cyp-**iapt**/*

THE NHS INFORMATION CENTRE— WORKFORCE AND FACILITIES (2009) General and personal medical services. England. 1998–2008. Leeds, The Health and Social Care Information Centre.

TOMSON, D. & SHIERS, D. (2003) Primary care mental health: a new dawn. *Primary Care Mental Health,* 1**,** 5-8.

TONELLI, M. (2007) Conflict of interest in clinical practice. *Chest,* 132**,** 664-70.

TOOP, L. (2011) The QOF, NICE and depression. *Brit J Gen Pract,* 61**,** 432-433.

TUDOR HART, J. (2006) *The political economy of health: a clinical perspective,* Bristol, Polity Press.

TYLEE, A., HALLER, D., GRAHAM, T., CHURCHILL, R. & SANCI, L. (2007) Youth-friendly primary care services: how are we doing and what more needs to be done? . *Lancet,* 369**,** 1565-73.

URQUHART, C. (2001) An Encounter with Grounded Theory: Tackling the Practical and Philosophical Issues. IN TRAUTH, E. (Ed.) *Qualitative research in IS.* London, Idea Group Publishing.

USTAN, T. & SARTORIUS, N. (1995) *Mental illness in general health care: an International study,* Chichester, Wiley.

VALLANCE, A., KRAMER, T., CHURCHILL, R. & GARRALDA, M. (2011) Managing child and adolescent mental health problems in primary care: taking the leap from knowledge to practice. *Primary Health Care Research & Development,* 12**,** 301-309.

VAN DER HART, O., NIJENHUIS, E. & STEELE, K. (2006) *The Haunted Self: Structural dissociation and the treatment of chronic traumatization,* New York, W.W. Norton & Co.

VANDANA, J. & AMBELAS, A. (2004) General practitioner preceptions and practice related to adolescent depressive presentations. *Clin Child Psychol Psychiatry,* 9**,** 341-346.

VEIT, F. C. M., SANCI, L. A., YOUNG, D. Y. L. & BOWES, G. (1995) Adolescent healthcare - Perspectives of Victorian General Practitioners *Medical Journal of Australia,* 163**,** 16-18.

VIET, F., SANCI, L., A, YOUNG, D. & BOWES, G. (1995) Adolescent health care: perspectives of Victorian general practitioners. *Med J Aust,* 163**,** 16-18.

VINER, R. M. & BARKER, M. (2005) Young people's health: the need for action. *BMJ,* 330**,** 901-903.

VINER, R. M., OZER, E. M., DENNY, S., MARMOT, M., RESNICK, M., FATUSI, A. & CURRIE, C. (2012) Adolescence and the social determinants of health. *Lancet,* 379**,** 1641-52.

VINEY, R. & BHATTI, N. (2010) Coaching and Mentoring. *BMJ Careers*.

VINEY, R. & MCKIMM, J. (2010) Mentoring. *British Journal of Hospital Medicine,* 71**,** 106-9.

WEST, P. (1997) Health inequalities in the early years: is there equalisation in youth? *Soc Sci Med,* 44**,** 833-58.

WESTMAN, A. & GARRALDA, M. (1996) Mental health promotion for young adolescents in primary care: a feasibility study *Br J Gen Pract,* 46**,** 317.

WHITE, M. (2007) *Maps of Narrative Practice,* New York, W.W. Norton & Co.

WHITEHEAD, M. & DORAN, T. (2011) The north-south health divide. *BMJ,* 342**,** d584.

WHO (2007) International Statistical Classification of Diseases and Related health Problems. 10th ed. Geneva, WHO.

WHO AND WORLD ORGANIZATION OF FAMILY DOCTORS (WONCA) (2008) Integrating mental health into Primary Care: a global perspective.

WHO. (2001) The second decade: improving adolescent helath and development. Geneva, World Health Organization.

WIEBE, E. & GREIVER, M. (2005) Using cognitive behavioural therapy in practice: qualitative study of family physicians' experiences. *Canadian Family Physician,* 51**,** 992-3.

WONCA, W. A. (2008) Integrating mental health into primary care: a global perspective.

WOOD, D. F. (2008) Problem based learning. *BMJ,* 336**,** 971-971.

YOUNG MINDS (2011) For children and young people: better mental health-friends and family. London, Young Minds.

ZANTINGE, E. M., VERHAAK, P. F. M., DE BAKKER, D. H., KERSSENS, J. J., VAN DER MEER, K. & BENSING, J. M. (2007) The workload of general practitioners does not affect their awareness of patients' psychological problems. *Patient Education and Counseling,* 67**,** 93-99.

ZWAANSWIJK, M., VAN DIJK, C. & VERHEIJ, R. (2011) Child and adolescent mental health care in Dutch general practice: Time trend analyses. *BMC Family Practice,* 12.

APPENDICES

Appendix A: Ethical Approval Documentation

A1. Ethical approval NHS Regional Ethics Committee

National Research Ethics Service

Hull & East Riding Local Research Ethics Committee
Research Ethics Office
Humber Mental Health teaching NHS Trust HQ
Willerby Hill Business Park
Willerby
HULL
HU10 6ED

Telephone: 01482 389246
Facsimile: 01482 303908

22 October 2008

Dr Jane Roberts
Clinical Senior Lecturer in General Practice
County Durham PCT
University of Sunderland
Centre for Primary & Community Care
Green Terrace, Sunderland
SR1 3PZ

Dear Dr Roberts

Full title of study: How do GPs approach and diagnose persisting psychological and emotional distress in young people? : An exploratory study.

REC reference number: 08/H1304/97

The Research Ethics Committee reviewed the above application at the meeting held on 20 October 2008.

Ethical opinion

- Members agreed that this application was very well presented and is an important area of research for General Practice

- For interest only members wish to know how the findings of this study will be validated -- please email this information to Louise Hunn at louise.hunn@humber.nhs.uk

- It was strongly suggested that paragraph 3 under the heading of "Will my taking part in this study be kept confidential" in the information sheet should be highlighted in bold to emphasise the importance of the information

Members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
CV - Ann Crosland	Version 1	24 September 2008
CV - J A Gledhill	Version 1	24 September 2008
Further Information - Participant Information	Version 1	24 September 2008
Participant Consent Form	Version 1	24 September 2008
Participant Information Sheet	Version 1	24 September 2008
GP/Consultant Information Sheets	Version 1	24 September 2008
Covering Letter	Version 1	24 September 2008
Protocol	Version 1	24 September 2008
Investigator CV	Version 1	24 September 2008
Application	Version 1.1	24 September 2008

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

234

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study
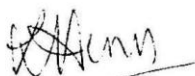
The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H1304/97	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr David Horton
Chair

Email: louise.hunn@humber.nhs.uk

Enclosures:	List of names and professions of members who were present at the meeting and those who submitted written comments
	"After ethical review – guidance for researchers"
Copy to:	Mr Simon Kerridge

A2: Ethical certificate University of Sunderland Ethics Committee

UNIVERSITY ETHICS COMMITTEE

APPLICATION REVIEW FORM (RV1)

Application Number: **2008.100**

Project Title: **GP Perspectives on adolescent psychological distress in primary care.**

CONDITIONS: These conditions must be completed before you commence the work.

APPROVED

RECOMMENDATIONS: The committee recommends the following are completed before the work commences.

Note: If you require to make any significant changes to this approved protocol, you must apply for a new ethical review.

Conditions have been completed……………………………..………Date…………
Chairperson

RC GP Royal College of
General Practitioners

Dr Jane Roberts
University of Sunderland
Centre for Primary and Community Care
School of Health, Natural and Social Sciences
Priestman Building
Green Terrace
Sunderland
SR1 3PZ

25th September 2008

LETTER OF ACCEPTANCE – REVISED 8th December 2008

Dear Jane,

Ref. SFB-2008-06 / How do GPs approach and diagnose persisting psychological and emotional distress in young people? An exploratory study.

Thank you for your application to the Scientific Foundation Board for a grant for the above project which was considered at the committee last week and I am delighted to say that we are able to fund your application up to a maximum of £3,850.57. We were all impressed by the rationale for the project and the quality of your proposal.

Please note that recipients of awards from the Scientific Foundation Board are required to make their first claim against their award within six months of the date of this confirmatory letter. Failure to do so can result in the withdrawal of the grant. We also ask that recipients complete and return a short *First Six Months Progress Report* after six months of the date of this confirmatory letter and a copy of the form to be used for this is enclosed.

Should it transpire that Research Governance (Ethical Approval) is required for this study, I need to point out that the Board is unable to release grants until Research Governance has been obtained. I would be grateful if you could let the Administrator to the Board at the College, have a copy of the letter of approval should approval be required. Arrangements will then be made to notify you of how to claim your grant.

In the event that delays occur in obtaining Research Governance which mean that you could exceed the six months limit referred to above, please note that you must write to me, via the Clinical Innovation and Research Centre at the College, explaining the circumstances and requesting an extension.

Finally, in the current climate of reduced income from its investments, the Board's decisions are becoming increasingly competitive. I therefore offer you our sincere congratulations on your successful application. We wish you all the best with the project.

Please contact Zanet Jirout at the Clinical Innovation and Research Centre (Administrator to the Board) for further information.

Yours sincerely,

Professor Helen Lester
Secretary, Scientific Foundation Board

Stockton-on-Tees **NHS**
Teaching Primary Care Trust

Ref: RE-MM403

24th October 08

Teesdale House
Westpoint Road
Thornaby
Stockton-on-Tees
TS17 6BL

Tel: 01642 666700
Fax: 01642 666701

Dr Jane Roberts
University of Sunderland
Centre for Primary and Community Care
School of Health, Natural and Social Sciences
Priestman Building
Green Terrace
Sunderland SR1 3PZ

Dear Jane

GP Perspectives on adolescent psychological distress in primary care

Stockton on Tees Teaching Primary Care Trust and Hartlepool Primary Care Trust give approval for this project to begin, subject to the following:

- Approval from the Local Research Ethics Committee

- All Accidents and Complaints related to the research are reported to the PCT

- Serious Adverse Events affecting local patients are reported to the PCT promptly

- The RM&G Unit is informed of any changes to the original Protocol before those changes are implemented

- The researchers will provide assistance with any Monitoring or Audit required by the PCT

- The research will not require any financial support from the PCT, unless there is a written agreement to the contrary.

- The PCT and RM&G Unit are informed when the project ends

Best wishes in your research.

Yours sincerely

Marie Clark
Lead for Research Management and Governance

cc: Richard Errington, RM&G Unit Lead

Mr Graham Prest, Chairman
Mrs Chris Willis, Chief Executive
Dr Carl Parker, Executive Committee Chairman

A partner in the Primary Care College for Tees and Durham - learning and working together

239

A5: Middlesbrough and Redcar

Stockton-on-Tees *NHS*

Teaching Primary Care Trust

Our Ref: PJK/LS
Your Ref: RE-MM402

28th October 2008

Tower House
Teesdale South
Thornaby Place
Thornaby
Stockton-on-Tees
TS17 6SF

Tel: 01642 352297
Fax: 01642 351644

Dr Jane Roberts
University of Sunderland
Centre for Primary and Community Care
School of Health, Natural and Social Sciences
Priestman Building
Green Terrace
Sunderland
SR1 3PZ

Dear Dr Roberts
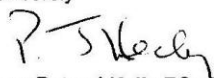
GP Perspectives on Adolescent Psychological Distress in Primary Care

Middlesbrough PCT and Redcar and Cleveland PCT gives approval for this project to begin, subject to the following conditions:

- Approval from the Research Ethics Committee with Site Specific Approval (SSA) where appropriate.

- Honorary Contracts being issued where relevant.

- Any Accidents and Complaints related to the research are reported to the PCT through the usual systems

- Serious Adverse Events affecting local patients are reported to the PCT promptly

- The RM&G Unit is informed of any changes to the original Protocol before they are implemented

- The Researchers will provide assistance with any Monitoring or Audit requests from the RM&G Unit or the PCT

- The research will not require any financial support from the PCT, unless there is a written agreement to the contrary.

- The PCT and RM&G Unit are informed when the project ends

Best wishes in your research.

Yours sincerely

Professor Peter J Kelly BSc PhD FSS CStat MFPH
Teeswide Executive Director of Public Health

Copy to: The RM&G Unit.

Mr Graham Prest, Chairman
Mrs Chris Willis, Chief Executive
Dr Carl Parker, Executive Committee Chairman

A partner in the Primary Care College for Tees and Durham - learning and working together

NHS

NHS County Durham
and NHS Darlington

County Durham & Tees Valley Primary Care Trusts'
Research Management & Governance Unit
County Durham PCT
John Snow House
University Science Park
Durham
DH1 3YG

Tel: 0191 301 1300
Fax: 0191 3744100
Safehaven Fax: 0191 374 4102
www.countydurhampct.nhs.uk

Our ref: RE-MM418/ R&D No: 380
Your ref:

21 November 2008

Direct Line: 0191 374 4211
Reception: 0191 374 4103
Email: richard.errington@nhs.net

Dr Jane Roberts
Clinical Senior Lecturer in General Practice
University of Sunderland
Centre for Primary & Community Care
Green Terrace
Sunderland
SR1 3PZ|

Dear Dr Roberts

GP Perspectives on adolescent psychological distress in primary care
REC Ref: 08/H1304/97
R&D No: 380
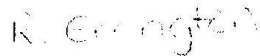
County Durham PCT and Darlington PCT give approval for this
project to begin, subject to the following conditions:

- Approval from the Research Ethics Committee with site-
  specific approval where appropriate.

- Honorary Contracts have been issued where relevant.

- Any Accidents and Complaints related to the research are reported to the PCT(s) and RM&G Unit through the usual systems.

- Serious Adverse Events affecting local patients are reported to the PCT(s) and RM&G Unit promptly.

- The RM&G Unit is provided with copies of any updated documentation after NRES approval and before it is implemented.

- The Researchers will provide assistance with any Monitoring or Audit requests from the RM&G Unit or the PCT(s).

- The research will not require any financial support from the PCT(s), unless there is a written agreement to the contrary.

- The PCT(s) and RM&G Unit are informed when the project ends.

Best wishes in your research.

Yours sincerely

Richard Errington
RM&G Unit Lead

A7: Letter of Invitation

Centre for Primary and Community Care   Date

Priestman Building

Green Terrace

Sunderland

SR1 3PZ

Dear Dr

I am a GP working in Easington, Co Durham and also a Senior Lecturer at the University of Sunderland. I am undertaking a research project which aims to explore how GPs approach consultations with young people who may be experiencing mental health problems. This research will form part of my proposed PhD and your help would be greatly appreciated.

Please find enclosed a study information sheet. Further details are available on request.

I would be very grateful if you would kindly complete the reply supply attached below and return to me in the SAE. Alternatively you can contact me by email.

jane.roberts@sunderland.ac.uk

Thank you for your consideration of my request to take part in this study.

Yours sincerely

Jane H Roberts MBChB MRCGP MSc

	Please tick box
Name : Tel No to contact Best time to ring	
I have received the information regarding the study entitled 'GP Perspectives on adolescent psychological distress in primary care'	
I would like to participate in the study	
I would be happy to be contacted by Dr Jane Roberts to arrange to meet	
I choose not to be involved in the study	

Thank you

Participant Information Sheet

Study title: GP perspectives on adolescent psychological distress in primary care

Researcher: Dr Jane Roberts

I am a General Practitioner and Clinical Senior Lecturer at the University of Sunderland, employed by County Durham PCT. It is intended that this project will form part of my PhD.

I would like to invite you to take part in this research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish

Please contact me if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

Purpose of the study

This study has been designed to look at how GPs approach a consultation with a young person who appears to be suffering or is at high risk of suffering a mental health problem.

Why have I been chosen?

A number of GPs working across Northumberland, Tyne and Wear have been approached with the aim of recruiting between 15-20 GPs working in different settings.

Do I have to take part?

No, you are under no obligation to take part in this study. When we meet I will describe the study and go through this information sheet, which I will hand to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time during the interview, without giving a reason.

Due to the design of the research the tapes will be transcribed promptly after the interview and analyzed in order to inform subsequent interviews. As a consequence of this process it will not be possible to remove your contribution to the study after this point.

If I decide to take part?

You will then be asked if you would be willing to take part in a face-to-face interview lasting no more than one hour. This will take place at a location of your choice. The interview will be an informal discussion exploring your experiences of consulting with teenagers (approximately aged between 12 -19 years) who may be experiencing mental health problems.

The interview will be digitally recorded and then transcribed to enable future analysis of results. All information will be anonymous and confidential. No personal identifiable information will be used in this study.

Upon completion of the study, you will be given a summary of the overall results in written format. You will also be given the opportunity to feed back any comments to me, if you wish.

What are the possible disadvantages and risks of taking part?

I do not anticipate any overt risks or disadvantages to you taking part in this study. If clinical commitments require your attention before we have finished then we will terminate the discussion.

A list of educational resources and contacts will be provided if you wish to pursue further a particular aspect of child and adolescent mental health in primary care.

What are the possible benefits of taking part?

I cannot promise the study will help you but the information we get from this study may help improve the way we, as General practitioners, work with young people who may be experiencing psychological distress. It could also contribute to the future training of GPs in managing adolescent mental health in primary care.

What if there is a problem?

If you have a concern about any aspect of this study you should contact me, Dr Jane Roberts, at the contact details at the bottom of this sheet.

If you wish to discuss your concerns further, you can do this through the University of Sunderland by contacting my research supervisor, Professor Ann Crosland, using the contact details at the end of this information sheet.

Will my taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence.

All data collected as part of the interviews will be collected and stored at the University of Sunderland. It will be kept in password protected electronic sites and paper documentation will be kept in locked filing cabinets. Data will be anonymised and coded. It will be kept for three years and destroyed upon completion of the study.

If, during the course of the interview, any information relating to clinical malpractice or criminal activity is disclosed to the researcher, this information will need to be referred to the clinical directorate of your PCT.

What will happen to the results of the study?

The results will be made available to all the study participants. The results may be published in academic journals. You will not be identified in any report or publication as all information you give will have been anonymised.

Ethical review

All research carried out in the NHS is reviewed by a Research Ethics Committee comprised of an independent group of people, whose function is to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the xxxxx Research Ethics Committee.

How long do I have to decide?

Please could you let me know within three weeks of receipt of this information sheet, if you are willing to be involved in this study? If you do not want to take part, you do not need to do anything further.

Thank you for your time and participation in this study.

For further information please contact:

Researcher: Dr Jane Roberts

Clinical Senior Lecturer in General Practice
University of Sunderland
Centre for Primary & Community Care
Priestman Building
Green Terrace
Sunderland
 SR1 3PZ

e-mail: jane.roberts@sunderland.ac.uk
 Tel: 0191 515 2420
 Fax: 0191 5152229

Academic supervisor: Professor Ann Crosland

University of Sunderland
School of Health, Natural and Social Sciences
Fleming Building
Sunderland
SR1

e-mail: ann.crosland@sunderland.ac.uk
Tel: 0191 515

CONSENT FORM

Study No: 08/H1304/97

Study Title: GP Perspectives on Adolescent Psychological Distress in Primary Care

Researcher: Dr Jane H Roberts

Please initial box

1. I confirm that I have read and understood the information sheet dated for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time and without giving a reason.

3. I agree to having the interview audio-recorded and transcribed.

4. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of person taking consent	Date	Signature

When completed 1 for participant and 1 for researcher site file

V1 24/09/08

A10: IRAS lay summary

GP Perspectives on Adolescent Psychological Distress in Primary Care: Lay summary

Adolescent mental ill-health is a common problem. Studies show between approximately 10%-15% of teenagers experience symptoms which result in personal suffering and psychosocial impairment yet the majority of young people experiencing distress are undetected in primary care. For example, studies have shown that up to 75% of young people experiencing symptoms suggestive of a depressive disorder will not have their problems recognized by healthcare professionals in primary care settings with whom they come into contact.

The detection and diagnosis of psychological distress in young people is not straightforward. We know that GPs admit to a lack of confidence when dealing with teenagers who may have a mental health problem and consider that their training does not prepare them adequately.

What is not known is how GPs respond to a young person who appears emotionally upset and may be suffering a mental health problem in order to best help them. We also know very little about how GPs view their role in terms of the health promotion of emotional well-being in young people.

This study aims to begin to address the gaps in our knowledge regarding GP's management of adolescent psychological distress. If more is known about how adolescent mental health problems presenting in primary care are dealt with then we can begin to look at how we might improve our low detection rates.

The study proposes to explore GPs' experiences of consulting with young people who may be suffering mental ill-health. It looks at the extent to which GPs consider the possibility of mental health problems where it is not explicit and how they respond to these potentially challenging consultations. In addition, the study aims to identify what factors inhibit or help GPs in making decisions about young people's mental health. Finally, it will gather GPs' views of possible interventions which could be offered to young people to improve services for this underserved group.

A11: Participant demographic details

GP Interviewee Demographic data

Please circle

Identifier	
Age	20-30 31-40 41-50 51-60 60+
Sex	Female Male
Country of origin	
Country of medical graduation	
Year qualified	
Postgraduate training	
Postgraduate qualifications	
Current employment status	Salaried Partner Free-lance Locum

Appendix B: Interview Schedules

B1: Early Topic Guide

1. I'd like to talk about your experiences of consulting with young people in general

- How do you find this age group?

- Is it very different to consulting with older patients?

- What sort of problems do you see? Do they consult often?

2. Can we talk more about consulting with young people who may have psychological/mental health problems

- How do you find this clinical area?

- What about seeing YP alone/with 'another'

- Any areas particularly tricky to broach?

3. How do you consider possible 'mental health problems' which present in young people?

- Do any examples come to mind?

- What approach did you take?

- What worked well? What was difficult?

- Is it different with other age groups?

4. What are your thoughts on 'depression' and 'anxiety in young people?

- Do you see much of it?

- Does this differ from other age groups?

- What options are there in primary care?

5. Do you think GPs have a role/or not in promoting emotional well-being in young people? Explore

B2: Revised Topic Guide

1. In general how do you find consulting with young people (broadly aged 12-19 years)?

- Do you see many?
- Do you enjoy seeing this group? Or not?
- What conditions/presentations do you generally see with this group? Gender differences?

2. Thinking more about young people with possible mental health conditions:

- Have you had had much experience?
- These consultations have been described as 'challenging' - would you agree?
- Why is this the case? [looking at barriers]
- What might make it easier?
- What has worked for you in the past?
- What about your experiences /comments on secondary care/care services [Prompt: CAMHS; school nurses, voluntary groups]

3. Thinking about particular styles of consulting:

- Can you describe your preferred style?
- Preferred area of clinical practice?

4. Considering the bigger picture - do you see the wider changes impacting on how we respond to young people with psychological problems:

- Re QOF; NICE; PCT guidelines; RCGP direction
- How have the above impacted on your practice?
- Has your practice changed over time - as a result of external changes or because of other factors? [triage; appointment systems; skill mix and new roles]

5. Professional identity and values:

- What is important to you about being a GP?
- How do you see the role of GPs in addressing young people's mental health?
- How does it sit within general practice?

Appendix C: Theoretical memos and field notes

C1: Theoretical memo after analysis of 05: 01/04/09

Some fabulous insights in this interview. I felt more relaxed + as result-talked much less.

Key ideas emerging around risk-assessment, management. 'Risk in the room' - teenagers experiencing low moods are risky-they are unpredictable, changeable, labile.

Fear and anxiety on part of GPs can inhibit communication-block asking important questions; leave 'elephants stranded in the room' (Martinez, Reynolds, Howe, 2006): mutual reluctance on both sides (GPs + YP) to acknowledge psychological difficulties. Responsibility seems to be on part of YP to begin the discussion.

C spoke often of 'coping strategies', 'difficulty coping' as a precursor to MHP-post trauma, a learned behaviour – generational/environmental; as a subject which could be raised in health promotion discussions.

Importance of early identification of psychological difficulties is not to make specific diagnosis but TO OFFER SUPPORT and ideally psychological therapies which can foster healthier coping strategies. This is a different angle to the psychiatrists who aim for diagnosis - based on diagnostic categories, to instigate Tx, to monitor/ reduce rates of relapse/recurrence.

She identifies a clear line of demarcation: when teenage moodiness transgresses into disease territory: when it impacts on function - then it needs attention - intervention or watchful waiting. Follow-up. Never mentioned much of a problem with YP not attending for F/U In one case suggested non re-attendance likely due to a pattern f the YP having been let down by professional services (+ family) on many occasions.

Her style is collaborative-working with the YP: sharing information + negotiating treatment options, discussing at what point to intervene, always watchful of level of risk + safety. Avoids coercion. Clear about confidentiality being dependent on no CP issues arising. Is able to contain a lot of emotional/mental health stuff in PC.

Offered a fresh approach. Distinct move away from paternalism + taking on board patient's problems; creating dependency. Promotes empowerment, autonomy, problem solving behaviour.

Completed first 'messy' situational map this evening: Identifying Who and What are in the broader situation.

C2: Theoretical Memo based on interview 11: 10/06/09

Collegiate, confiding tone in which she seeks affirmation and approval from me that she is not alone in finding these consults challenging

Brilliant case study of the angry hurt young man

As a young female GP she sees many young girls-13/13/15/16 wanting contraception-Implanon popular + so for her the sceptre of child protection looms large fairly early on: sex under 16 yrs is illegal. She is aware that providing sexual health services can be seen to be condoning under age sex which positions GPs with a dilemma-how to offer protection without either encouraging, or condoning or positively advocating...

CASH is the bridge: YP KNOW they need/want it and where to access it unlike emotional health issues which are much harder to define and require a degree of emotional literacy which is not always present-requires confident, capable, able, emotionally healthy parents to inculcate + foster 1) YP often don't realize they have a problem and 2) may be unable to articulate it-unless asked and facilitated

 Plus: the issue of confidentiality if a parent is present.

And disturbing relationships with the family-parent by asking them to leave...

I've had a couple of them where I have asked, in the nice way, asking the adult if I could just have a minute alone with them and that's also quite difficult as well asking somebody to leave but in a, trying to do it in a nice way without damaging....You know, they are obviously sitting outside thinking 'what are they talking about in there?', and am sure as soon as the young person goes out they are probably, 'what you been talking about?', so that... and then you think 'have I done more harm than good by asking the older person to go out??'

Older GPs rarely spoke about experiencing difficulties asking parents to leave-even if they had anticipated it-but then many would have had a relationship with the adult, unlike the newer younger GP

Her presenting concern re managing YP MHP is the short fall in secondary care provision: its virtual status-not seen/not known

...whereas CAMHS team: I don't know where they are, I don't know how they are, well you know obviously don't know where they are but **I feel like I have no relationship with them at all** and the school nurses ,which I suppose is the other port of call, erm, again I feel quite, it's probably my fault and need to go and introduce myself or something like that but I don't feel like I have a relationship so much with them, I mean I'm sure there is a phone number somewhere.

This idea is reproduced in all i/vs outside of X=the absent or very poor relationship between CAMHS and GP appears to disable many GPs and inhibit further engagement with YP. The structure of all secondary services influences referral patterns: these are not objective, criterion led activities: depends on quality of service, accessibility, openness of   SCT to develop a relationship with PC, human networking, resources and capacity of SCT.

CAMHS/PC seems a particularly fraught tense relationship with antagonism on both sides

Quality of referral is particularly poor hence high rates of being bounced back- referrals poor because GPs don't engage with YP-find out nature + extent of problem-anyone else involved-SN's or school counsellors?

People talk about 'the place to be' and oh you know she has been to 'the place to be' and had some counselling and things but I don't really know who runs that or so I feel a bit detached from the services that, yes I am probably revealing all my short comings now,

Personal anxiety about not knowing the extent of services available nor of having established a relationship with providers

Expressed her lack of confidence in providing psychological support for YP whilst more than happy to do it with older people and presupposes that it is because she feels YP do not actively want to see her/i.e doubt that she has something useful to offer - therefore she doubts herself.

Her confidence in seeing OP is because they are trusting in her therefore she repays that trust by acting appropriately.

But this may not be a factor of experience: see, similarly - P does not routinely see YP with MHP UNLESS there is a substance abuse problem - 'I might enjoy it but I know my limits - time, capacity, skills'

Her lack of confidence seems to come from

1. Unfamiliarity and lack of faith in the Secondary Care Sector

2. Lack of faith in own agency as perceives YP not interested in seeing her for her own sake + potential to help-constructs their apparently hostile exterior ('always swearing') as a sign 'to keep out' and appears to interpret that as confirming she would be useless??

3. Lack of practice - much less common to see a YP with MHP or even behavioural problems – so not routine consults

4. Has no children of her own

5. No training/preparation as an undergrad-and even worse-only experience being sent to IP unit for the most disturbed YP:

'But that was like where we went as students and it was erm, people with severe anorexia who were being re-fed and much more the severe end of the spectrum which you don't, which you obviously don't really see so much well you wouldn't be dealing with in general practice so much so. In terms of normal no, no, not really, hardly any.'

The Triadic Consult creates a problem because it is almost always initiated by the adult - can inhibit a GP from engaging with YP if s/he perceives GP attention is unwanted-is this a feature of inexperience or does it reflect consulting style/clinical interest in psycho-social problems?

Do older (parent) GPs unwittingly collude with the adult who presents in distress (in a triadic consult with a silent, truculent looking YP)

And/or do younger GPs sit closer to the YP?? identify more with their distress and feel inhibited in their capacity to 'do something' including listening

Identifies barriers as

GPs - prejudice, preconceived ideas, lack of confidence in initiating dialogue, fobbed off by YP's 'hostile' exterior

YP-naive consulters, unfamiliar with the process + script, unable to express themselves

Parents-normalizes teenage mood changes - dismisses lability: 'Oh "they're just a teenager "and there again that's another barrier because they are "just teenagers" and 'just being moody' and' just being bad tempered' or whatever that that's another barrier to them getting help if it's needed maybe.

I've heard it loads of time, from parents,

'Yeah and you're not aware cos if you say to me why didn't I respond to that when people have said oh they're just teenagers, like I don't know why I didn't respond?'

'falsely reassured by family saying she's a monster but laughing....'

Not wanting to medicalize - emotional liability

Contrary to the psychiatrists - YP can present upfront with emotional symptoms-clear from the outset-usually much easier for the GP to respond to-plonking the box on the table

Skills required call upon relationship counselling – YP in context of a relationship with family/members

'You often, all this, when the exams are over things will feel better and just cos there's a lot happening. Mind you, there is a lot going on in everybody's life isn't there? but erm, so it's no different to an adult really. Oh yeah a lot of similarities. **I suppose if I saw them more in my mind the way I see adults it might enable me more. I think a lot of it is my confidence to deal with it'**

Interesting-that is the approach of the Transitions Service psychologist-to treat YP as young adults-unless they revert to child-like mode-give them the benefit of acting autonomously

She presents the inherent conflict in striking a balance between asking sensitive questions in a routine manner and choosing to use some form of judgment as to when and with whom you raise the question. Manifests her own unease at identifying certain patients in the 'at risk group' and not others

'You feel as if you're wrong saying that if the parent is a drug user therefore I am worried about child protection cos that seems like a wrong link to make doesn't it, but yet it is something that happens'.

'No, I always ask about suicide, everybody with mental health thinks about it, we have had five people killed in the last three months, and that's a massive, It's a, we have written a big letter to the PCT and it's all, it's not all teenagers thank god but erm, it's all young men in their 20's, 30's. Four of them have hung them selves, three of them who had not been to the doctor at all, and the other.. so it was all very impulsive acts. It's really hard, so we are all completely obsessed with it at the moment.'

Interesting blur between talking about having an internal agenda of tick-boxes and responding to covert cues or hunches –which are viewed as prejudices and negative even tho; the stats would bear out-more drug using parents assoc. with abuse than not

'I probably mean given our position, why am I not more confident at it, I think that's what I mean. And I don't mean that I think I am particularly hideous at it, but probably that I don't feel like it is, like it is I you know I suppose the reason you are doing this study is that it's a funny area isn't it, it has got a lot of black clouds hanging over it, it's a possibly a one that people think 'oh here we go- how am I going to do this?? I know, I will send them to CAMHS, great; Bye'

'I am sure it's a massive area that is under met so yes I think it probably I think more training in general I don't know if QOF, I think QOF is very helpful in a lot of ways that the structure and make sure that everybody is doing certain basic parameters but better way of going about it might just be more support and training for GPs in adolescent consultations you know how to ask the questions about feeling low and it's a different way of asking that you would ask an adult, they might not even know what depression is'

C3: Theoretical memo: on the process of producing axial codes 20/08/09

This is a process of analysis in which the data appears to present itself open to other interpretations than first appeared during the stage of open coding. I continue to see the material as malleable and permeable and open to multiple interpretations. So far nothing completely 'new' is striking me but the links and separations between early categories are shifting. I am seeing 'age' as a category collapse and two more clearly identified categories [or possibly groups of GPs] emerge. These gather around axes of experience and degree or level of awareness of psychological problems in young people and are not mutually exclusive.

The first category includes experience gathered from a number of sources. These may include considerable contact with young people through offering contraception and sexual health services; often as a consequence of being the only young and or female GP in the surgery or because of the practice's demographics such as being an elite university town practice. Experience may have been gleaned from a previous spell working for CAMHS or training with skilled and inspiring paediatricians. Personal experience has been formative for some. For example this might include close involvement with a neighbour's teenage son who was increasingly disabled by anxiety; contact with teenage children and their friends (although being a parent per se was dismissed by one GP as not necessary facilitating interaction with teenage patients since it depended on the quality of the relationship between parent and child) or one's own experience as a teenager and reflecting on the degree of support received by parents who may themselves have been going through a difficult phase.

The second emerging category refers to the spectrum of differing levels of awareness GPs present when considering the emotional worlds of their younger patients. This links to experience. Certain GPs were able to talk more readily about the contextual worlds of their patients, of the range and intensity of pressures they are increasingly subject to, of the intensity of their adolescent life experiences, of the range of idioms and speech patterns they draw upon which are often different to those of adults and of the changing nature of family structures which might compromise emotional health in adolescence.

Regarding the development of themes identified earlier-social class is emerging as a 'mixed bag' with regard to emotional literacy, ability to cope with everyday challenges and confidence in communicating with adults in formal settings, such as GPs. The triadic consult remains seen as a challenge in the context of adolescent patients where it seems to reflect a particular intensity of interaction and potential for conflict; given that patients of any age (beyond childhood) are often seen in surgery accompanied by another person.

A previous study (Iliffe et al, 2008) found that GPs perceived YPs as 'qualitatively different' in terms of their use of primary care. The data gathered here suggests that difference may be in the 'eyes of the beholder' and that there in fact a number of similarities between young people and other groups of patients. These include a tendency to present psychological problems with an 'entry ticket' of a physical problem and the varying degrees to which an underlying emotional problem is articulated, particularly in the age group of 60 years plus. Young people were not considered by this group of patients to be any more likely to somatize than any other group of patients.

Differences did emerge regarding patterns of communication between GPs and older patients with the latter group much more familiar with the 'typical script' of a consultation and much more likely to 'play the game', containing their problem in the 10 minute time frame of a usual consultation. Young people were seen as 'more difficult to engage with', often needing more time to open up and establish trust in contrast to older patients who were perceived as being more ready to accord trust to a doctor by virtue of their professional standing rather than the quality or the nature of the consultation. Communicating with troubled young people was viewed by some as requiring a degree of sensitivity and greater attention to their contextualized worlds which are often less 'visible' than the stresses of 'middle aged life' although to a younger GP seeing patients aged 40 plus was much more challenging than seeing 17 year olds presenting with suicidal thoughts or paranoid delusions. Referring back to Clarke, p85:

Doing situational analysis as an exercise to open up the data - 'what seems present but (is) unarticulated?

What are the sites of silence? - these are more visible in my hand-drawn positional maps.

How can I pursue these sites in the next round of sampling without putting words in participants' mouths or 'forcing the data?' (Charmaz, 2006)

Need to go back to my earlier situational maps and explore the possible relational analyses in order to think about what is not being said + of what is being said - what is the most/least important - see diagrams

So far - key concepts include: experience linked to awareness of the complexity, contextual nature of detecting and diagnosing low mood/DD in YP.

Concepts: my anchor points-chief means for establishing relationships between the data (Blumer, 1969) Clarke p.109

C4: Field notes on interview 13: 25/2/10

First impressions

Very young! Qualified 2001. In first & only post for five yrs-initally f/t; now five sessions/wk. One other experience of general practice in J_____ (on VTS)-rich elderly miserable women with empty nests & money in the bank but no warmth in their lives.

Friendly but a little nervous. Not too keen to chat beforehand. Made a cup of tea-been on visits all morning. Just finished for the day/week.

When we had finishes and switched off tape she said it had been hard to do/found some questions v difficult because she had recently been off work for 6m with serious illness. Felt out of practice and as if not seen that many young people recently. She is the MH QOF lead in practice - does the reviews + collates the data

What seemed to be important

- That it wasn't difficult to talk with YP

- That close family support and open channels of communication made her job much easier

- That it was not the place for jobbing GPs to take on a specialist role with MH&YP but she could see a place for GPwSI

- A good, accessible, approachable CAMHS service was essential

- Being young and with clear memories of teenage years + (medical) student days meant she was able to identify with YP

What was new

- Service changes were for the better - NICE and other guidelines had produced improvements in practice e.g improving access to talking therapies for pts with MHP. Referred to an in-house teaching session with PCT and CAMHS - encouraged early referral, answered with prompt response - two emergency cases of young men who were suicidal - seen within the week by PMHWs

- That the future of general practice is positive-producing more diversity and specialization of services for patient benefit

- Being a salaried GP is good-even if you get paid much less and you never know what the partners earn. Working in a happy friendly practice counts for a lot.

- All encounters with social services had been positive!

- Frequent attendance in any age group indicates a problem-at home? Emotionally-needs exploring in any age

- GPs have become more approachable through CASH services

- The receptionists filter appts for YP to the five female GPs in their 30s.

- Consultation style is not a personal fixed trait but flexible-responds to time of day/week, mental state of GP, presenting complaint, contextual factors, who is in the room, prior knowledge of family

- Biggest change to providing quality of care is disruption of continuity of care through altered appointment systems

- Very positive experience of YP coming back to see her - on her own, on a number of occasions

- Open upfront presentations from family

- No skeletons in cupboards and no problems asking a parent to leave. Straightforward triadic consults OK – only starts to get tricky when extra adults added to the melee

- No problems discussing DSH and suicidal intent: always begin with open Qs and if on stony ground - asks very direct questions

Inhibitory factors

- My first interview after long break

- Responding to her being a little guarded; felt I was prompting rather a lot but she was not really in full flow

- She had mentioned she was not keen on being tape recorded

- I think her positive response to some Qs rather knocked me off guard at times & I had to rephrase many Qs. She hadn't really given this area much prior thought but it wasn't a big deal for her. She seemed switched off to some of the big debates in general practice-which she would with a recent life threatening diagnosis, 6m sick leave and a two yr old

Contextual factors

- Sitting at doctors desk-she in big high chair, me sitting in lower chair at corner

- Room was very functional, no external noises

What was my role?

- Scene setter, establish a rapport, put her at her ease, explain questions, encourage reflection

- Keen to be kept informed of outcomes of research-will contact

C5: Field notes on interview 18: 10/06/10

First impressions

Very late - 30m - thought we had run out of time. Obviously thoughtful-identified this as important in personal + professional life.

What seemed to be important

Acknowledgement of the importance of being a parent in equipping GP to deal with situations

Care of pts is important-duty of care to a YP is higher than a 34 yr old - we have a responsibility to them.

EWB of YP is a core duty of GPs - we are accessible although (many caveats), available and we have good basic skills at supporting; hand-holding; lifestyle advice; brief interventions and even working with more seriously ill YP.

YP are not a different group. They go through a challenging time of transitions and multiple potential stressors but then so do women who are menopausal - *I guess it's about the capacity to misunderstand and if got wrong - MHP in YP could be disastrous*

Rarely saw young men

What was new

Being asked for a hug at the end!!

Not being uncomfortable with silences in consults

Being clear that parents in the room are a barrier + rarely helpful

Notion of good GP - generalist, all rounder, not going too much in depth-dealing with a variety of presentations – enjoying being the fire-fighter and the co-constructor when needed-but time limits the latter.

Acknowledging that disappointment with CAMHS might in part be due to high/unrealistic expectations

Working intuitively with YP - suggesting someone keep an art diary-always seeking out a mutual point of interest to have a meaningful conversation

Asking the big Qs:

- Is it that GPs don't feel able to take on working with YP?

- Or is it the current fashion that YP with MHP should be managed by secondary care?

No salaried GPs in practice

<u>Inhibitory factors</u>

None – quiet undisturbed room

<u>Contextual factors</u>

Knowing each other professionally meant that the initial part of interview went well-flowed smoothly

<u>What was my role</u>

As ever - juggling covering the topic guide with allowing the GP to take the discussion where it feels relevant to them

Respecting confidences + honest admissions of culpability and human frailty-not always being available for patients - may be distracted, emotionally/physically worn out

C6: Field notes on interview 19: 01/07/10

First impressions

Bit nervous. Not keen on the audio-recorder but agreed as useful for me - said she was aware of it during the interview but it wasn't obvious to me that it bothered her.

Felt she had more to say but was slow at gathering her thoughts - said she found some of the questions difficult to answer.

What seemed to be important

That managing YP's MHP could and should be part of core general practice but isn't.

That it requires time, persistence and energy - with a willingness to run over time.

That understanding youth culture is irrelevant. It is experience – both personal + professional and all mixed up which matter.

We need to improve our service to YP - by better preparing GPs and spreading the word to YP that they can receive help here.

What was new

The tricky bit is the triadic consult - it isn't about getting YP to talk.

They will most likely always present with physical Sx - need to develop trust in the GP and need to be seen over a number of occasions.

Depression is under-recognized-reduced presentation and missed - put down as stress-only to keep recurring in adulthood

Has changed her style over time - now more of an explorer and would lean more that way with longer consults

Thinks Gen Pract is still something of a "shut door" to YP - and they have a teen clinic in their practice

Inhibitory factors

Her nervousness re the tape. Sandwiched between a meeting and her next surgery

Contextual factors

Good central location. We had never met before. I had been quite pro-active in contacting her-she obviously enjoys this group of pts but normally avoids any 1:1 questioning/interviews.

What was my role

To push her a little - why do you say that? What advice would you give to a GP Reg?

What would you say to a GP who said the H promotion of YP's MH is not our role? No-one would deny that YP MHP's are problem – who should get involved? Definitely GPs

Appendix D

The OPEN CODES

<u>**GP Factors**</u>

Age

Gender

Level of experience.

Skills in Interaction can be emotionally charged.

Managing confidentiality with building rapport

The 'FIRST CONSULT' - how important is this? What's at stake?

'Illness Presentations' what do young people come with? How is it picked up by the GP?

Looking for cues (or not)

Attendance/frequency patterns of consulting

Non-verbal behaviour. Managing tension in the consult.

Trying the GP out

Seeing things at face value

Transitional questions - moving form the physical to the psychological

Picking up on the cues:

TIMING

BROACHING THE TOPIC

Using intuition

ASKING DIFFICULT QUESTIONS: alcohol, drugs, sex, home life

Seizing the moment

GP CONSULTING STYLE.   COMMUNICATION SKILLS

"Dr as the obstacle/barrier"

Reflexivity - thinking about your practice.

Inadequate preparation

Coping with uncertainty - building trust.

GP ANXIETY- managing anxiety

Reluctance to open up dialogue - 'to go there'

Fear

Anxiety around asking difficult questions. Confidentiality.

Uncertainty and unpredictability which characterize adolescence

Lack of clarity around legal status - re consulting alone with a young person

Some GPs not happy to see them on their own

Poor service provision - what's available?

External pressure - negative societal images of YP

Lack of clinical supervision

Embarrassment

Limited repertoire of options available in primary care

Inadequate training

Limited guidelines. No 'ticky boxes'.

Unclear expectations

GPs Role in Health Promotion of Emotional Well-Being of Young People

GIVING INFORMATION AS EMPOWERING TOOL

GPs working holistically

Developing a therapeutic relationship

Behavioural interventions to help moderate Sx of depression

GPs thoughts on what young people might want

Whose role is it to offer emotional support?

Talking about drugs and alcohol

SCREENING

What is the value?

Who should do it? Why?

What should GPs use?

MAKING A DECISION

Who knows what is best?

GPs can disagree with CAMHS? With parents?

Who has responsibility for care?

Factors around CAMHS/secondary/other Tier 1 service provision

Criteria for referral to CAMHS - what are they? Seem to vary?

Everything has to go 'through CAMHS' but hard to get referrals accepted 'a lottery'

PROFESSIONAL DISSONANCE BETWEEN PRIMARY AND SECONDARY CARE SERVICES-DISTRUST

BRIDGING THE GAP

Psychological distress is manifest differently

Differences in service provision: availability, access, quality

Other Tier 1 options? - what is available?

Young People Factors

Socio-economic factors

"YOUNG PEOPLE AS A DIFFERENT GROUP TO ADULTS"

The importance of the contextual background. Role of the family.

Young people's sense of time

Assessing what they want; embarrassment

TEENAGE LOW MOOD-hard to distinguish between low mood and serious problem

Prevalence

Importance of the context of the setting (of presentation/consultation)

What is normal? Different social norms

Changing all the time

Triadic Consultations

Difficult

Who is in charge?

Who brings what to the table?

How to deal with confidentiality?

Communication in general difficult

Assessment of Mental Health Problems

Muddled

Early presentations - listening for alarm bells

Difficulties with assessment - defies neat classification - no' yard sticks'

Behavioural problems are the presenting problem

RISK ASSESSMENT: These are high risk consultations often-difficult to judge with any sense of objectivity

Family Life

 Asking about abuse and violence

Using direct and indirect or open questions

Self harm - difficult to know what to do

Responding to 'suicidal ideation' - complex

Making a decision

'Sadness' versus 'depressive disorders' - how to tell the 'difference'

GPs role in managing 'depression' - persisting low mood

269

What is it?

Outside Influences

TIME

General practice is very pressured now

So much to cover

Teenagers need lots of time

Often undemanding

Appointment systems

What's available?

Guidelines - lack of. What's the effect of QOF?

Ways of understanding emotional distress

The Biomedical Frame

'Somatization'

Polarity of serious pathology dominating-in training; in the way GPs think about illness

Vignettes of extreme cases e.g severe anorexia

Depression as a disease

Other ways of understanding distress

Seeing context as important

Psychosocial distress. Trauma. CBT model

Life events

Sharing the story, different versions

Appendix E: Situational analysis diagrams

E1: MESSY SITUATIONAL MAP 15.04.09

teenage pregnancy rates

Families, dynamics; history

Fear

hoodies, thugs, ASBOS

bullying

RISKY

unknown territory

need for control/discipline

Media

Young People

GPs

RCGP

Internet

care/cure

Drugs, Alcohol; smoking

receptionists

surgeries

communication skills

'teenage moodiness vs depression'

Psychiatry

CAMHS

Depression and Anxiety as disease category

DSH not a disease category

Medication

groups at risk

Read codes, DSM

hot topics in medicine-debates-health promotion

Referral systems

School nurses

NHS NICE

guidelines;QOF;Protocols

Technologies

E2: ORDERED SITUATIONAL MAP
26/05/09

INDIVIDUAL HUMAN ELEMENTS

GPs

Young people

CAMHS PERSONNEL

Receptionists

Practice nurses

GPs as a collective polity nationally
and at surgery level:

Local organizational culture, ethos,
philosophy

PCT, BOTH +VE & -VE influence

How YP are perceived societally

DISCURSIVE CONSTRUCTION

GPs as problem solvers-responders to
situations

Not seekers of problems (ambiguity of
Mx of LTC as core, onerous work??)

YP are 'difficult' to communicate/
engage with - a problematic group

Limited secondary services

Ad hoc and scanty contact with YP
lack exposure hence experience

NON-HUMAN ELEMENTS

Surgery layout, structure, building

Atmosphere, ambience

Nature of services/surgeries offered

Local CAMHS services

Pharmacotherapy

School nurses

NICE GUIDELINES

(Heterogeneity)

COLLECTIVE HUMAN ELEMENTS

SILENT ACTORS

KEY EVENTS IN THE SITUATION

**DISCURSIVE CONSTRUCTIONS OF
NON-HUMAN ACTANTS**

Screening

Role of PC/GP in MH health promo

QOF

Rates of detection of depression/MHP
in YP

Concepts of gender, socio-economic
status

POLITICAL /ECONOMIC ELEMENTS

Organization of CAMHS

Role of PCT

Structure and payment of PHC in UK

Commodification of care

Biomedical science and EBM as engines and ontological framework

Structured care-guidelines and protocols

SPATIAL ELEMENTS

Socio-economic geographical variations

Poverty and its relationship to MH

SOCIO-CULTURAL/SYMOBLIC ELEMENTS

Diagnosis of depression

Role of GP in managing MHP in YP

Society's view of YP as problematic - 'hoodies, thugs, 'macabre Goths'

Contemporary parenting practices - high rates of abuse, neglect

TEMPORAL ELEMENTS

Hx of psychiatry - filtered through prism of PC

Bio psychosocial model - importance of narrative and continuity of care

Less emphasis on diagnosis/DSM category

Process of diagnosis is different (Glaziou, BMJ series, April-May 2009)

Theories of causation-'trauma', stress-vulnerability model, biochemical, genetic, environmental

RELATED DISCOURSES

Screening in adult MH

Mx of Depressive Disorders (DD) in adults

MAJOR ISSUES

DD in YP - an entity, misery or something more?

Medicalized or ignored? Or something else?

Value of early intervention [BMJ Head to Head series, April, 2009]

Role of medication

Quality/distribution/organization of services

OTHER KEY ELEMENTS

Emotions expressed by GPs:

Anxiety, discomfort, fear

Risky consultations

Power relationships in general practice

Social World/Arena Map:

E3: For GPs

General Practice

Patients

PCT

CAHMS

Legislation

Voluntary Sector

BMA

Secondary Care

RCGP

NICE

Counselling

DH

CPD

QOF

Media

Pharma

Society
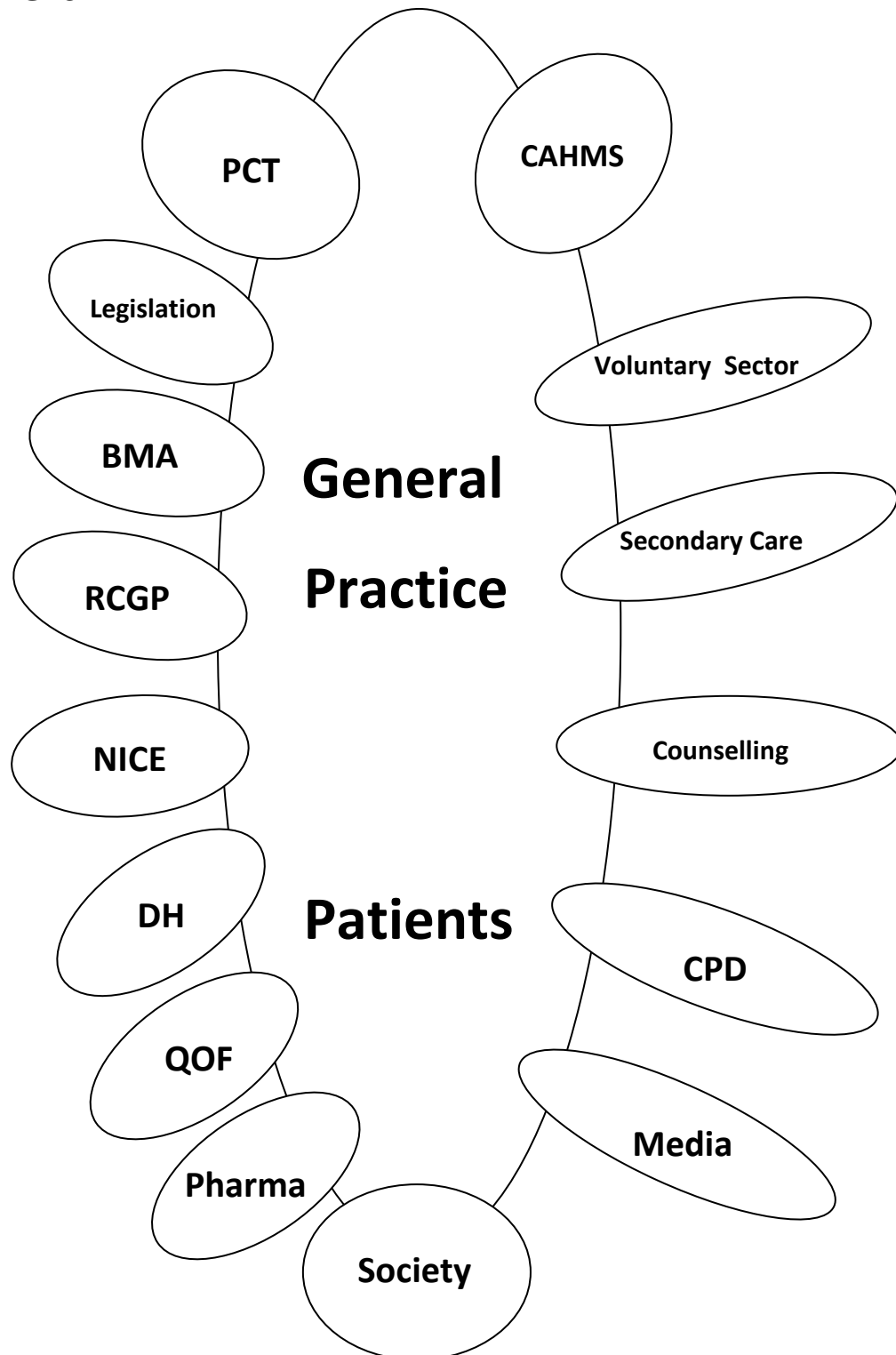
Social World/Arena Map:

E4: For Young People
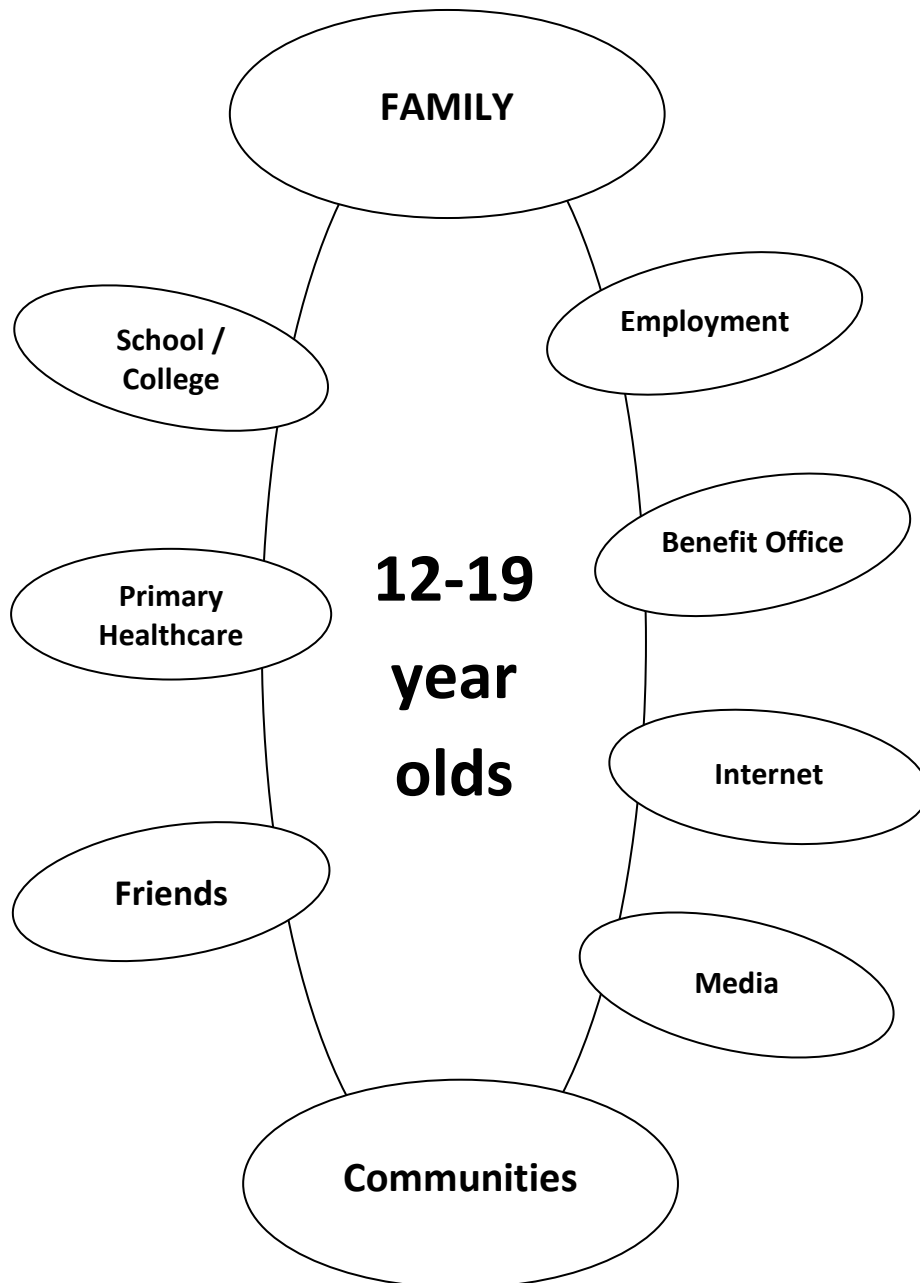
POSITIONAL MAP

E5: Relationship between GPs' ability to create positive relationship with Young People (y axis) and the CAMHS service (x axis)

+ve   diagnosis is 2ndry to interpersonal skills   working with YP, families and CAMHS is maximally

Quality of   Contact + relationship with CAMHS is   preferable position-creates more streamlined
relationship   independent   better referrals

MISSED POSITION   Quality and organizational structure of CAMHS   determines

All-GP role is marginal

Good services create demand

-ve   Poor services-little faith-?fewer referrals

-ve   +ve

Poor service   Excellent service

CAMHS SERVICE: quality & relationship affect GP identification and management

E6: Young People as a 'different' group (Y axis) and GPs as advocators of emotional well-being and health promotion (X axis)

YP are not   GPs role is not be involved in H Promo   Health Promotion

a special group   x   for everyone   x

mid point

                                         x   x

YP are a special   GPs have no skills in promoting   It is critical that we support/empower

group   EWB in this GP   YP to develop resilience and good coping

                                                                  Skills

               NOT GPS ROLE   STRONGLY POSITIVE FOR GPS ROLE

GPs as advocators of Emotional well-being and health promoters

E7: Identifying mental health problems in Young People (Y axis) and importance of early identification of Mental Health Problems in Young People (X axis)

EASY   MISSING POSITION-in summer 09   Early identification is of unknown significance

To   Later: Younger GP saying it is easy to spot and important to refer early   Missed position

IDENTIFY

                        Most GPs in middle ground

                                                    Not important and difficult to spot

                                                    YPs needs are not seen

IMPOSSIBLE   X   X

                                        X   X   X

IMPORTANT TO IDENTIFY EARLY   **NOT IMPORTANT**

279
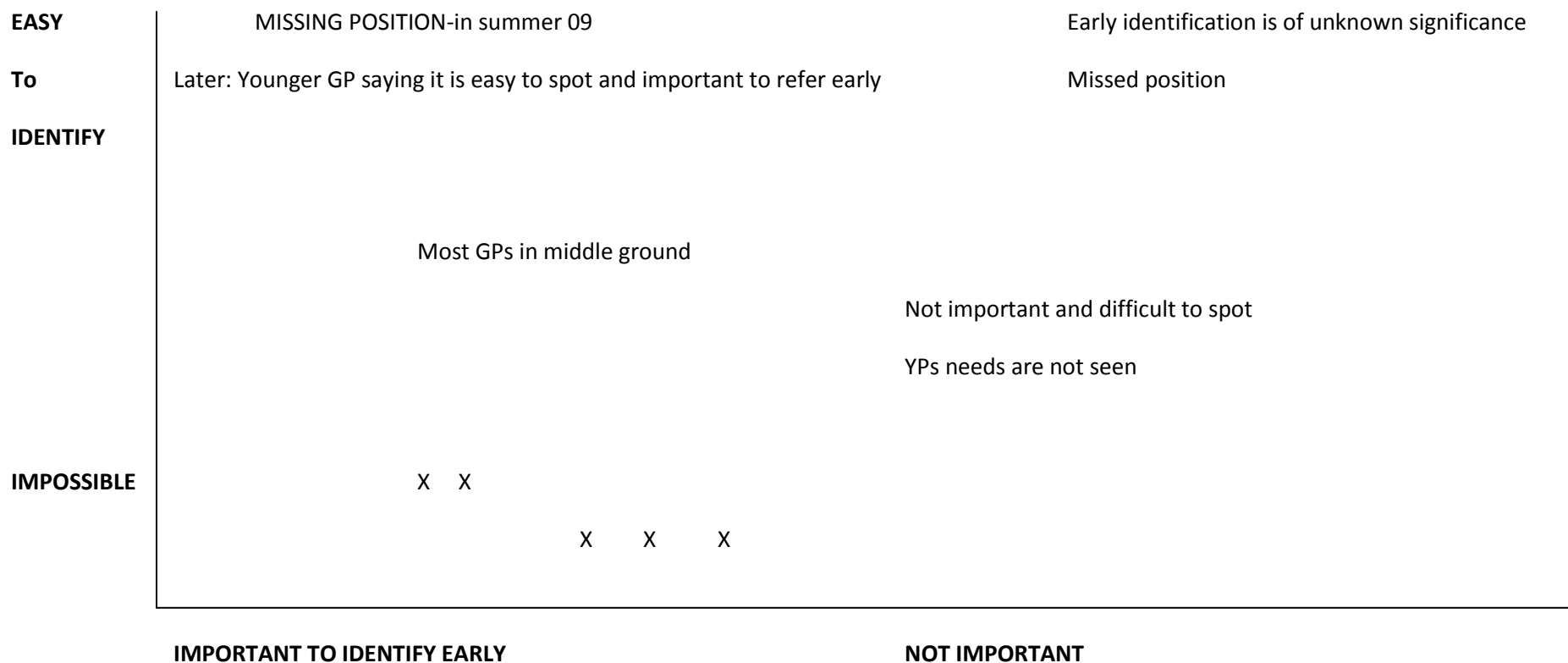
E8: Ability to share power and relationship with anxiety levels

(Y axis: holding onto power or sharing); (X axis anxiety levels from low to high)

```
                                      X                              X X X X

HOLDING              Impossible position?

ON                   tight control & feel relaxed

To

POWER

                         X XX X  X                 X                        X

                                          experience is the mediator    younger GP-parents take control

                                          Personal & professional

LETTING

GO
```

LOW ANXIETY   HIGH ANXIETY

RELAXED   UNEASY

Appendix F: Conceptual Maps

F1: GPs and Young People with mental health problems: whose problem is it? and why?

F2: Conceptual map - May 2009

Age;   Gender;   Anxiety; Uncertainty

GP

CONSULTING STYLES

Psychological mindedness

Risk aversion

FAMILIES supportive, 'over-bearing'

Socio-economic status

CAMHS

Visibility

Accessibility

Range of response

YP

Internal worlds

External worlds

Peers

F3: Conceptual model of competing influences and tensions 29 April 2010

Fire fighter   Problem
          Explorers

Young People's position

Anxiety, worry, confused

GP style

Approach
To
Practice

Socialisation

Uncertainty & Anxiety

Chaos, confusion, unease

Structural Influences

Time,
Policy, external
agenda, Mx
options

Ideology and values

Priorities

View of role of GP

GP Knowledge
3 areas

Knowing; doing;
being

How YP are viewed by GPs

Negatively or
with concern

283

F4: Conceptual model Axial codes 13 May 2010

YP

In transition; Family; anxiety, viewed negatively

GP style, Professional identity

Communication style

Priorities; Values

Emotional literacy

Experience

CAMHS

Visibility; approachability

Responsiveness; quality

GP

ANXIETY AND UNCERTAINTY

Value judgements-What is normal?

Threats to integrity-losing face

PRACTICE-ORGANISATION

VALUE; PRIORITIES

KNOWLEDGE

Knowing-content, CPD

Being-relational skills

Doing-engagement

QOF

NICE

284

Conceptual Map
21.05.09.

GP supporting YP when CAMHS have said 'no mental H problems'.

Age   Anxiety
Gender   Uncertain
         GP. Awkwardness

Consulting style
'psychological mindedness'
Intuition
Risk Assessment

Social networks.
Families
Rich ⇌ Poor

VIOLENCE
ALCOHOL
DRUGS.

Communication + mutual trickery of distress

Behavioural changes.

Spectrum of distress

Communication difficult

Context of adolescence.
YP   Peers.

Internal worlds
emotional landscapes
remain unknown
unseen
ignored.
unexplored.

Invisible
Unknown.
CAMHS
Unpredictable response

Barriers
Not a natural environment
Power differentials
Intimidating / Institut
Difficulty expressing self

GEOGRAPHICAL
VARIATION everything is directed to + thru'
CAMHS.

285

Experienced GP.

Family life.

Exposure to other ideas

Life Experiences - networks outside of Medicine

Broader Education - eg SocSci...
                                    Schools
Training
Med Education

Q.o.f.

Payments

Recognize
Complexity

CURIOSITY

Reflective.

COMPASSION

CARE

Guidelines

liaison

Communication
skills.

GP

Personal style
+ interests

involvement

engagement
flexibility

containment
of problem/
in place of
referral

*

Family <
                immediate
                extended.

YP.

Social world
contextualized.
valued.

Voluntary
services.

CAMHS

Appreciate negative
perceptions of society
- Adolescence á difficult
            time
rite of passage

Role of GP
    - Broader
see Health Proms
+ Empowerment
as part of core work

PCT:
leadership
direction
policy setting

Other
Professional
roles
eg FPC.

* willing to negotiate power ⇌

21/8/09.

286

Inexperienced GP
and/or 'Unaware'

Payments

Anxiety
-disabling → ineffective consultations.

Medics

Family

Communication
Style

Guidelines ———

GP

Protocols ———

YP

Dis
engagement

Schools

remains isolated

mistrustful of services

Quick referral

rejected
referrals
turned back

CAMHS.

No cross-
disciplinary
interaction
Poor awareness of each other's working realities
Mistrust

287

Dealing with Uncertainty

tve

-ve

View of the role of GP

View held of YP.

Personal Style Values

- Fixer or Co-explorer
- Advocate
- Facilitator
- Health Promote
- Liazion with other HCPs

- In Transitions or on a continuum
- Requiring support or Containment

- Patterns of Communication
- Emotional literacy
  - personality
  - personal circumstances

View of Medicine

Biomed Etc.

Education + CPD

Socialization into medicine

Acculturation

- Power sharing
- Therapeutic potency/ Agency

Youth Health
Adolescence — Development

17/16/10

288

Appendix G: HEADSS and HEEADSSS screening tools

G1: The HEADSS screening tool[i]

To assess general functioning in young people

H= Home

E= Education/ Employment

A= Activities : [social, internet, sporting, interests,]

D= Drugs/ Alcohol/Cigarettes

S= Sex

S= Suicide - to be asked only if the preceding questions have suggested a risk

[i] McCabe R. Psychiatric Disturbance. *Practitioner*. 1992; 236: 1150-4

G2: HEEADSSS Psychosocial Assessment[i]

Adolescent Psychosocial Assessment

HEEADSSS Psychosocial Assessment
Explain reasons for delving into sensitive areas and ask permission to proceed
H- Home (Consider - living arrangements, transience, relationships with carers/significant others, supervision, childhood experiences, cultural identity)
E- Education, Employment, Eating, Exercise (Consider - school/work retention & relationships, bullying, belonging, study/ career progress & goals)
E- Eating, Exercise (Consider - nutrition, vegetarianism, eating patterns, weight gain/loss, exercise, fitness, energy)
A- Activities, Hobbies & Peer Relationships (Consider - free time, hobbies, culture, belonging to peer group, peer activities & venues, lifestyle factors, risk-taking, injury avoidance, sun protection)
D- Drug Use (Consider - alcohol, cigarettes, caffeine, prescription/Illicit drugs and type, quantity, frequency, administration, interactions, access, increases/decreases- treatments, education, motivational interviewing)
S- Sexual Activity & Sexuality (Consider - knowledge, sexual activity, age onset, safe sex practices, same sex attraction, history pap smears/STI screening/abuse, pregnancy/children)
S- Suicide, Depression & Mental Health (Consider - normal vs clinical, suicidal ideation/intent/method/past attempts/treatment, anxiety, reaction to stress, sleep- depression score & mental state exam)
S- Safety, Spirituality (Consider – sun screen protection, immunization, bullying, abuse, traumatic experiences, risky behaviour, belief, religion; What helps them relax, escape? What gives them a sense of meaning?)

Mental Status Examination

Appearance and General Behaviour		**Mood** (Depressed/Labile)	
Thinking (Content/Rate/ Disturbances)		**Affect** (Flat/Blunted)	
Perception (Hallucinations)		**Sleep** (Initial Insomnia/Early Morning Wakening)	
Cognition (Level of consciousness/delirium/ intelligence)		**Appetite** (Disturbed Eating Patterns)	
Attention/Concentration		**Motivation & Energy**	
Memory (Short & Long term)		**Judgement** (Ability to make rational decisions)	
Insight		**Anxiety Symptoms** (Physical & Emotional)	
Orientation (Time/place/ person)		**Speech** (Volume/Rate/ Content)	
Significant cultural factors		**Significant support person**	

[i]GOLDENRING, J. & ROSEN, D. (2004) Getting into adolescent heads:An essential update. *Contemporary Pediatrics*, 21, 64-90 (proforma sourced from CHOWN P. et al 2008. *GP Resource Kit*. Sydney, NSW CAAH)