Jane Roberts, Ann Crosland and John Fulton

GPs' responses to adolescents presenting with psychological difficulties:

a conceptual model of fixers, future planners, and collaborators

Abstract

Background
Psychological difficulties are common in adolescents yet are not often addressed by GPs. Anxiety and uncertainty about professional practice, with a reluctance to medicalise distress, have been found among GPs. GP involvement in this clinical area has been shown to be influenced by how GPs respond to the challenges of the clinical consultation, how they view young people and their perception of their health needs, and a GP's knowledge framework.

Aim
To explore the relationship between the above three influences to develop an overarching conceptual model.

Design and setting
Qualitative study based in 18 practices in the north east of England. The practices recruited included rural, urban, and mixed populations of patients predominantly living in socioeconomically disadvantaged communities.

Method
Theoretical sampling was used to guide recruitment of GP participants continuing until theoretical saturation was reached. Data were analysed using the constant comparative method of grounded theory and situational analysis.

Results
In total 19 GPs were recruited: 10 were female, the age range was 29–59 years, with a modal range of 40–49 years. Three levels of analysis were undertaken. This study presents the final stage of analysis. GP 'enactment of role' was found to be the key to explaining the relationship between the three influencing factors. Three role archetypes were supported by the data: 'fixers', 'future planners', and 'collaborators'.

Conclusion
The role of GPs in managing adolescent psychological difficulties is unclear. Policy advocates a direct role but this is unsupported by education and service delivery. GPs adopt their own position along a continuum, resulting in different educational needs. Better preparation for GPs is required with exploration of new, more collaborative models of care for troubled adolescents.

Keywords
adolescent psychological difficulties; GP consultation style; youth mental health.

INTRODUCTION

Psychological difficulties associated with mental health disorders in adolescents, defined by the World Health Organization as 10–19-year-olds,[1] are common.[2] Previous studies have found that adolescents who visit their GP have higher rates of psychological problems when compared with adolescents who do not visit their GP, as shown in community surveys,[3–5] yet detection rates by GPs are low, unless the problem is severe.[6] Detection of emotional distress, which is generally subsumed with emotional or internalising disorders (typically depression and anxiety in the published literature),[5,7,8] is even less well detected.

Numerous explanations have been offered for this. Low rates of GP self-reported confidence, attributed to scant preparation in the undergraduate curricula, have been reported.[9,10] This is supported by recent findings which identify GP registrars as not feeling confident in responding to adolescent mental health problems (S Dawlatly, Secretary RCGP Adolescent Health Group, personal communication, 2014).

Adolescent presentations in primary care are often complex and coexist with behavioural, psychosocial, academic, and familial problems, which can be challenging to untangle.[11] However, if they are left unexplored, they can have long-term sequelae that impact on social and family relationships, academic and employment histories, and health behaviours in adult life.[12]

Although adolescents consult GPs frequently,[13] they are much less likely to raise emotional distress as a presenting complaint,[14,15] and will often wait for an invitation from the GP.[5,14] Consultations for younger patients have been reported as being shorter, despite having to cover more complicated terrain such as confidentiality and consent.[16–18]

At the same time there has been an increasing focus at policy level to describe a role for GPs in addressing emotional distress and responding early to psychological difficulties.[19–21] National Institute for Health and Care Excellence guidelines advocate GPs as front-line practitioners charged with identifying early indicators of difficulty.[22,23]

However, much less is known about how GPs perceive their role in responding to psychological difficulties in adolescence. Anxiety and uncertainty about professional practice have been found to dominate consultations in this arena, regardless of age or experience of the GP,[24] but GPs vary in their response to professional anxiety with adolescent mental health problems.[25] This article presents data, building on an earlier analysis, to investigate the factors that influence GP engagement in this clinical arena. The key influences were found to be a GP's performance in the clinical encounter; a GP's view of young people and their perception of health needs; and a GP's preferred epistemological framework.[25]

This article explores the interrelationship

JH Roberts, PhD, FRCGP, RCGP Clinical Champion for Youth Mental Health, Northern Strategic Clinical Network primary care mental health lead; **A Crosland,** PhD, professor of nursing; **J Fulton,** PhD, principal lecturer in health, Faculty of Applied Sciences, University of Sunderland, Sunderland.

Address for correspondence
Jane Roberts, CIRC, RCGP, 30 Euston Square, London NW1 2FB.

E-mail: jane.roberts@rcgp.org.uk

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How this fits in

GPs have low detection rates for psychological problems in adolescence, which can be complex, and they express anxiety and uncertainty about practice. GPs vary in their level of engagement with adolescent mental health problems according to their consultation style, awareness of adolescent development, and their preferred knowledge framework. This research presents three archetypes of GP behaviour in response to adolescent psychological problems: the fixer, future planner, and collaborator. The archetypes practise differently and have different educational needs.

between these domains and the impact on practice. A conceptual model is presented that proposes a framework for understanding GP behaviour when faced with adolescent psychological difficulties.

Table 1. Demographics of study participants

Participant ID	Sex	Age, years	Salaried or partner	Practice descriptor	Additional professional experience
01	F	50–59	S	Semi-rural, deprived	GP Postgraduate education
02	M	50–59	S	Urban, deprived	Addiction medicine in primary care
03	F	50–59	P	Urban, deprived; wealthy student population	Former associate specialist in CAMHS
04	F	40–49	S	Semi-rural, deprived	Mental health lead for a PCT
05	F	20–29	S	Urban, deprived	
06	M	40–49	P	Semi-rural, largely affluent	
07	M	40–49	P	Semi-rural, mixed	Child protection lead for a PCT
08	F	30–39	S	Semi-rural, mixed	
09	M	50–59	P	Semi-rural, mixed	GP lead for 'teen drop-in' clinic
10	M	40–49	P	Urban, deprived	Mental health and child protection lead for a PCT. Substance misuse
11	F	20–29	S	Urban, deprived	
12	M	30–39	S	Semi-rural mixed: largely affluent	
13	F	30–39	S	Urban, deprived	
14	M	40–49	P	Urban, deprived	
15	M	40–49	P	Semi-rural, mixed	
16	F	20–29	S	Urban, deprived	
17	M	30–39	S	Urban, deprived	
18	F	40–49	P	Semi-rural, affluent	
19	F	50–59	P	Semi-rural, mixed	Child health lead

F = female. M = male.

METHOD

Study design

The study took place in the north east of England in 18 general practices based in urban, rural, and semi-rural communities serving predominantly socioeconomically disadvantaged patients. Data were collected between January 2010 and May 2011.

Participants

Nineteen GPs were recruited using theoretical sampling, which identifies participants on the basis of their demographic characteristics and ability to contribute to disproving or confirming emerging themes, including inviting 'outliers' who might challenge the developing themes. For demographic details of the sample see Table 1. Further details of the recruitment process are reported elsewhere.[24]

Data collection and analysis

GPs were interviewed individually in a location of their choice by one author (a GP) using interview topic guides (based on the literature) (Appendix 1). The interviews lasted 50–75 minutes and were audiorecorded and transcribed verbatim with consent.

The transcripts were coded and analysed using the constant comparative method of grounded theory,[26,27] and iteratively commented on. Recruitment of GP participants continued until theoretical saturation had been reached.

Using the stepped model of grounded theory, the open codes were derived first and presented elsewhere.[24] The second level of analysis defined the axial codes presented in a companion article by the authors,[25] which form the pillars of the conceptual model. The final stage of analysis, presented here, determines the theoretical construct (or selective code), which accounts for all the data and which unifies the underpinning themes to produce an overarching conceptual model.

RESULTS

Iterative analysis of the data suggested that the unifying theoretical construct to explain GP engagement is the perception and enactment of the GP's role in responding to adolescent psychological difficulties.

The empirical data collected in this study support a typology of three role archetypes: the 'fixer', the 'future planner', and the 'collaborator' (named using *in vivo* codes).

Although three role types are substantiated by the data, it is important to state that there is a continuum within each role, with 'grey areas' located at the boundaries of each role type. Based on the

Box 1. Quotes from GPs acting as 'fixers'

'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)

'... (teenage) *medical problems can be relatively easily dealt with, always nice to deal with easy problems, so some kind of medical straightforward disease things you know I'm thinking about acne, contraception ... no point making it more complex than it is.'* (02; M; 50–59; S)

Fixers and their performance in the clinical encounter

'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)

'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 seems 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, probably prescribe a bit more than average.' (17; M; 30–39; S)

'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)

Fixers' perspectives on young people and their health needs

'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 come into it.' (09; M; 50–59; P)

'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

'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 borderline diabetes and send them for fasting blood sugar. I don't have the out and out objective tests.' (06; M; 40–49; P)

'If they've got a good relationship with some teachers they might talk to them but school nurses, a bit of a joke really ... I never really found got anywhere, they never seemed to help the young person or me ...'. (01; F; 50–59; S)

Box 2. Quotes from GPs acting as 'future planners'

'... rather than a quick in and out I think I am more of a planner for the future rather than a firefighter type person.' (16; F; 20–29; S)

'... 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 ... and, I do like to chase numbers, you know "the perfectionist", 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)

Future planners' and the performance in the clinical encounter

'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's something you need to know I will be much more direct.' (16; F; 20–29; S)

'I think 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 they are getting on at school, what they enjoy doing.' (16; F; 20–29; S)

Future planners' perspectives on young people and their health needs

'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 with some people dabbling with drugs and alcohol, I think it's harder to deal with.' (13; F; 30–39; S)

'... 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 things? ... trying to sometimes empower them about, oh what you doing at school? ... What are your plans for the future?' (05; F; 20–29; S)

Future planners' epistemological frames of reference

'... 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)

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, label, and solve 'the problem'. GPs who operate as fixers work in 'the here and now' and ignore health promotion. Presentations of ill health are viewed pragmatically and young people's health needs are typically seen as uncomplicated (Box 1, 02; M, 50–59; S).

Analysis identified six of the GPs to be best described as 'fixers', including five males and one female; five of whom were aged 40–60 years and one male aged 30 years. The characteristics of this archetype will be presented below, mapped against the three influencing factors.

Fixers and their performance in the clinical encounter. Although the majority of GPs interviewed expressed feelings of anxiety, fixers more readily described this emotion associated with a sense of professional detachment (Box 1, 09; M; 50–59; P). Anxiety results in GPs adopting a 'doctor-centred' approach and restricts the topics of discussion to 'medical' areas, excluding more 'psychosocial' areas. The complex presentations of 'conflict at home' or 'anger outbursts' do not map easily to a fixer approach.

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 that might adversely affect their health. GPs working as fixers might not necessarily be comfortable with this method, but feel unable to perform differently (Box 1, 09; M; 50–59; P).

Fixers' epistemological frames of reference. Fixers operate within the positivist, biomedical paradigm,[28] which draws on factual theoretical knowledge and assumes universal, generalisable truths and an 'objective' clinician (Box 1, 06; M; 40–49; P). Positivists prioritise biomedical knowledge above all other sources of knowledge, see the young person's story as unsubstantiated, and marginalise other disciplines.

Future planners

The second role archetype supported by the data was the future planner. Future planners see difficulties stemming from

Box 3. Quotes from GPs acting as 'collaborators'

'... 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)

Collaborators and their performance in the clinical encounter

'... 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 to see the GP, or 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)

'I would never think of the young person in isolation. I will always think of the family. I am always looking at 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

'... and 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; P)

'... 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 ...' (10; M; 40–49; P)

Collaborators' epistemological frames of reference

'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)

Box 4. Quotes from GPs acting as 'floaters'

'I would say that I have bits of lots of those [approaches].' (18; F; 40–49; P)

'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 it's important to be aware of my limitations ... we are generalists.' (18; F; 40–49; P)

psychosocial distress; are proactive; and have a broader vision than the immediate presentation, seeking to equip patients to self-manage and take greater responsibility for their health. Conversation begins with the patient's agenda, then introduces 'doctor-centred tasks' (Box 2, 16; F; 20–29; S).

Seven of the participating GPs fitted this role type. Six were female, aged between 29 years and <55 years; one was a male in his late 40s.

Future planners and the performance in the clinical encounter. The GPs populating this group approached the demands of the triadic consult (adolescent–GP–carer/parent/third party) with a pragmatism that moderated their anxiety. For the four younger GPs in this role construct, their undergraduate medical education had equipped them with practical skills that facilitated talking to younger patients. Being less anxious encouraged greater curiosity and offered the young person the opportunity to talk about their concerns (Box 2, 16; F; 20–29; S).

Future planners' perspectives on young people and their health needs. Future planners demonstrated greater awareness of the challenges of adolescence than fixers. This sensitivity promoted compassion and an understanding that young people often needed time to be listened to.

A theme for this archetype was the importance of preparing young people to self-care through having more information about their health needs and reducing doctor dependency (Box 2, 13; F; 30–39; S).

Future planners' epistemological frames of reference. Future planners work in the biographical–biological paradigm, taking into account the context of the patient's life (Box 2, 05; F; 20–29; S). The influence of the family was seen as central, either as an enabling or a negative influence, and needed to be incorporated into the GP's management plan to be relevant for the young person.

Collaborators

The third role type seen from the empirical data was the collaborator (Box 3). This archetype describes a GP who sees the consultation as an opportunity to co-construct a meaningful account of the patient's story within the context of a mutually respectful, trusting relationship. Such an approach can empower the patient within his or her own environment, recognising the family unit as pivotal, but also remains mindful of the wider societal context.

Three GPs were considered to be collaborators from their described method; one female and two males all in their late 40s.

Collaborators and their performance in the clinical encounter. Collaborators also described feeling anxious in the consultation but used the emotion as a trigger for self-reflection and to examine the situation from the young person's perspective (Box 3, 04; F; 40–49; S).

Collaborators are more flexible in their approach so are able to handle 'the unexpected' or a 'cultural clash' occurring in the consultation appropriately.[25]

Collaborators' perspectives on young people and their health needs. Collaborators viewed young people less as 'a different species' but more as requiring a culturally and age-appropriate response. This may

not necessarily be a comfortable process and could involve 'awkward silences' but it demonstrated the commitment of the GP to work with the young person (Box 3, 06; M; 40–49; P) and build trust. They recognised that it was not feasible to expect adolescents to expose their vulnerabilities easily.

Collaborators' epistemological frames of reference. Collaborators operated in the interpretive paradigm.[29] This relationship-centred model of care sees the doctor–patient relationship as therapeutic in and of itself. It is a style that embraces health promotion in the consultation, within the context of the patient's lived experience, aiming to empower the young person.

With regard to time frames, where the fixer remains fixed in the present, and the future planner looks ahead, the collaborator works with the patient to incorporate threads from the past, present, and future.

Collaborators draw on multiple forms of knowledge and value the disciplinary perspectives of colleagues working in other specialties, such as school nursing or youth work.

The grey areas: the 'floaters'

This concluding section refers to those border areas at the margin of the archetypes. Three GPs did not sit easily within the core categories and several more described practice that moved between role types. One GP (Table 1, 11; F; 20–29; S) showed aspects of both the fixer and the future planner and so sat in the liminal area between the two. One older female GP sat between the future planner and collaborator role and spoke of movement between roles, according to external pressures and internal factors (Box 4, 18; F; 40–49; P).

DISCUSSION

Summary

This article presents an exploratory study in an underinvestigated area of clinical significance. The data generated demonstrated that GPs vary in their response to young people according to three influences, which have been brought together under a conceptual model.

According to a GP's performance in the consultation, which includes consultation style, a knowledge of the developmental processes of adolescence, and the knowledge framework within which a GP practises, the response to adolescent distress is shaped. Three different archetypes were supported by the data; fixers, future planners, and collaborators.

Strengths and limitations

Using grounded theory resulted in the development of a theoretical model in an area where understanding of GP behaviour is rudimentary and has been largely descriptive. The systematic use of theoretical sampling allowed for emerging ideas to be tested using the constant comparative method and to support the validity of the findings. Immediate analysis of completed interviews allowed findings to be incorporated into successive interviews, leading to the confirmation or abandonment of emerging theoretical ideas.

Involving young people in the data collection would have enriched the development of the model. The generalisability of the results to other settings is untested. While there is face validity for the model in other settings, its relevance to other contexts, including internationally, remains unknown.

Comparison with existing literature

Earlier work by Iliffe and others found GPs reluctant to medicalise depression and hesitant to begin conversations about distress, which results in disengagement and isolation for the young person.[30–31] Internationally produced work also reports GPs' reluctance to ask questions about emotional distress, which leads to lost opportunities to support wellbeing.[7,15] GPs describe anxiety and uncertainty about how best to respond to adolescent psychological difficulties,[24] and differ in their degree of engagement with troubled teenagers.[25] Screening for emotional distress has been advocated as a way to raise awareness of adolescent psychosocial problems but has been found to be most effective when linked to collaborative models of care.[8]

Dowrick and Reeve suggest that drawing on the wisdom traditions when faced with emotional distress might lead to a more healing response than the pursuit of a diagnosis and cure.[29,33] Dowrick's thesis supports the collaborator archetype that encourages therapeutic conversations in the consulting room as patient and GP look for meaning in 'lived experiences'.[33]

Implications for research and practice

The model reveals two important, connected aspects that impact directly on clinical practice. The archetypes show the different educational needs and levels of understanding of adolescent development.

Fixers need support with developing communication skills, which must be informed by a robust understanding of adolescent psychosocial development. A

fixer approach results in reduced empathy that can exacerbate distress,[14] and hastier referrals to child and adolescent mental health services (CAMHS), which are experiencing constraints,[33] thus a fixer approach can put additional pressure on the system.

Future planners would benefit from improved working relationships with local services including current information about services in the voluntary sector. The future planner approach encourages self-management and GPs would benefit from continuing professional development (CPD) that promotes positive youth development, rather than a risk-based model.[35,36]

Collaborators have different educational needs. Their tendency to work collaboratively means that they require access to experienced colleagues in CAMHS and, at best, clinical supervision.[37] They too need up-to-date information about local youth and secondary care services.

All approaches benefit from updated CPD that shares the increasing new insights into adolescent development from the basic and social sciences.[38]

The model has revealed the different training and educational needs for the three archetypes. These are underpinned by a global scarcity of good-quality, youth-informed medical education to equip doctors to consult with adolescents with greater confidence and competence. Adopting the internationally advocated 'life-course' approach to teaching about adolescence requires all educators to review their curricula and better prepare clinicians to promote good adolescent health.[39,40] The proposed model also invites further research which should explore adolescent perspectives on consulting with GPs who display different clinical approaches.

At a policy level there has been a recent call for 'named GPs' to provide continuity of care to patients aged <25 years who have mental health disorders.[41] This is yet another directive that values the role GPs could play, but which needs scaffolding with better educational support for GPs and closer facilitated working relationships with CAMHS. New models of collaborative care are also emerging and working in partnership with colleagues in youth work[42] (such as Association for Young People's Health GP Champions project; http://www.youngpeopleshealth.org.uk/5/page/71/gp-champions-project/) may offer new opportunities for future planners and collaborators to work more effectively with adolescents and address their emotional distress earlier in the trajectory.

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Appendix 1. Early topic guide

Focused on five broad areas, derived from the literature available at the time, to promote open discussion

1. I'd like to talk about your experiences of consulting with young people in general
   - How do you find this age group (12–19 year olds)?
   - 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 younger patients who may have psychological/mental health problems?
   - How do you find this clinical area?
   - What about seeing teenagers alone/with 'another'?
   - Any areas particularly tricky to broach?
3. How do you consider possible 'mental health problems' in adolescence?
   - Do any examples come to mind?
   - What approach did you take?
   - What worked well? What was difficult?
   - Is it different with other age groups?
   - Who else might be involved?
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?
   - What do you tend to do?
5. Do you think GPs have a role/or not in addressing/promoting emotional wellbeing in young people? Explore.

Subsequent refinement of topic guide included asking in addition about factors external to the consulting room. How do they impact?