Published in final edited form as:

Clin Pediatr (Phila). 2015 October ; 54(12): 1218–1220. doi:10.1177/0009922814566027.

The Effect of Parental Presence on Weight-Related Discussions Between Physicians and Their Overweight Adolescent Patients

Truls Østbye, MD, PhD^{1,2}, Pauline Lyna, MPH², Michael E Bodner, PhD^{2,3}, Stewart C Alexander, PhD⁴, Cynthia Coffman, PhD^{5,6}, James A Tulsky, MD^{2,5,7}, Rowena Dolor, MD, MHS⁷, and Kathryn Pollak, PhD^{1,2}

¹Department of Community and Family Medicine, Duke University, School of Medicine, Durham, NC, USA

²Cancer Control and Population Sciences, Duke Cancer Institute, Durham, NC, USA

³Department of Consumer Science, Purdue University, West Lafayette, IN, USA

⁴School of Human Kinetics, Trinity Western University, Langley, BC, Canada

⁵Durham VA Medical Center, Center for Health Services Research, Durham, NC, USA

⁶Department of Biostatistics and Bioinformatics, Duke University, School of Medicine, Durham, NC, USA

⁷Department of Medicine, Duke University School of Medicine, Durham, NC, USA

Introduction

Primary care physicians (PCPs) can influence patient behavior change. Among overweight and obese adolescents, changes in diet and exercise may prevent obesity into adulthood and lead to healthier and more functional lives. However, little is known about how physicians attempt to promote weight-related change with their overweight adolescent patients. Guidelines recommend that physicians address more than 20 topics during routine visits, including sensitive topics such as sex and drugs.¹ To promote honest disclosure, many physicians prefer to discuss these sensitive topics without the parent in the room.

Questions persist concerning “triadic communication” among adolescents, their parents, and physicians. Obese children frequently have obese parents, and parental presence may affect the quality of communication.² Physicians may find themselves needing to educate both child and parent, and parents may feel responsible for the adolescent. Thus, conversations are likely to differ depending on whether the parent is present or absent.

Reprints and permissions: sagepub.com/journalsPermissions.nav

Corresponding Author: Truls Østbye, Duke University Medical Center, Erwin Square 6002, Main Street, Durham, NC, USA 27710, truls.ostbye@duke.edu.

The funding organization had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

This study was registered at clinicaltrials.gov (ID: NCT01040975).

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

In this article, we assess whether parental presence during the PCP–adolescent visit enhances or inhibits weight-related discussions. In the current analyses, we take advantage of audio-recorded encounters from Teen CHAT (Communicating Health: Analyzing Talk), a study aiming to reduce obesity through improved physician–adolescent communication.³

Methods

Teen CHAT was approved by the Duke University School of Medicine Institutional Review Board. PCPs ($n = 49$) from academically affiliated and community-based practices gave written consent to audio record their encounters. PCP schedules were reviewed by study staff to identify eligible patients: English-speaking, body mass index ≥ 85 th percentile for age and gender, age 12 to 18 years, not pregnant, and with preventive or return visit scheduled. After parent and adolescent verbal consent/assent was obtained, a research assistant validated the adolescent's body mass index, using a standardized weighing scale and stadiometer, and audio-recorded the visit.

Discussions of body mass index/weight and 6 specific weight-related topics (ie, breakfast, fast food, diet, physical activity, screen time, and sleep), as well as whether a parent was present, were coded. Total time for each encounter was calculated.

Variables

The outcomes were seven dichotomous variables indicating whether a weight-related topic was discussed or not during the office visit. The topics were the following: weight, diet, physical activity, screen time, sleep, breakfast, and fast food. The predictor variable of interest was a 3-level categorical variable defining the presence of the parent in the encounter: (a) no parent present for entire encounter, (b) parent present for part of the encounter, and (c) parent present during the entire encounter. Covariates in these analyses included patient age, gender, and race.

Analysis

Analyses were performed using SAS software version 9.2. (SAS Institute, Inc). Descriptive statistics are presented, and a generalized linear mixed model with a logit link was used to examine the association of parental presence with whether weight-related topic discussed (accounting for clustering of patients within physician). The number of covariates that could be included (patient age, gender, and race) were limited because of the distribution of the dichotomous outcome variables.⁴

Results

There were 183 physician–adolescent encounters audio-recorded for the 49 enrolled physicians (Table 1).

Mothers were more likely (70%) than fathers to accompany teens to their medical visit. Younger patients were more likely to have the parent present during part or entire encounter; older patients were more likely to not have the parent present at all ($M = 14.1$, 95% CI 13.8–14.4 and $M = 16.4$, 95% CI 15.9–16.9, $P_s < .001$).

The duration of the encounters differed across the 3 parental presence categories ($P < .01$). The estimated mean time when the parent was present for part of the encounter (24.0 minutes, 95% CI 21.7–26.0) was longer than the mean times when either no parent was present at all (20.0 minutes, 95% CI 17.0–23.0) or the parent was present for entire encounter (19.0 minutes, 95% CI 16.0–21.3).

There was an association between parental presence and discussion of weight ($P = .03$). Specifically, when the parent was in the room for part of the encounter, physicians had 3.6 times the odds of discussing weight compared with when the parent was present for the entire encounter (see Table 2). No other significant associations were found between parental presence and discussion of other weight-related topics.

Discussion

This is the first report examining whether parents' presence in the room is related to physicians' discussions of weight with overweight adolescents. Our findings suggest parents should accompany their overweight/obese adolescent visits to the doctor as the overall length of the visit is longer, allowing for more detailed discussion of weight-related issues. Parents can also supplement their child's medical history and support the child during discussion of diagnosis and treatment.⁵ However, while parental presence/involvement can extend and enhance conversations, it is important that the parent be absent at least for part of the encounter to allow discussion of more sensitive topics. Physicians were less likely to address weight when parents were in the room the entire visit compared with when they leave for part of the visit. Potential explanations include that physicians are worried about offending parents of overweight children by talking about weight because the parents themselves are overweight, or that when parents present the entire time monopolize the conversation with their concerns, leaving physicians with little time to address weight.

Having parents leave is important as teenagers are likely to have more positive perceptions of the physician and report taking an active role in treatment when the encounter includes a sensitive health topic.⁶ Time alone with the PCP recognizes the adolescent's right to confidentiality⁷ and need for active contribution to their own socialization for both general and health issues. Strengths of the study include a racially diverse population and objective, recorded measures of encounter durations. Generalizability is limited to overweight/obese adolescents; however, this is an important group for interventions given their increased risk for adult obesity. The sample is relatively small, thus not allowing for subgroup analyses or detection of smaller effects. However, our sample included adolescents from rural, urban, academic, and community settings.

Conclusion

Parent involvement in adolescents' health must balance parental control and adolescent confidentiality/independence. Parental presence during overweight/obese adolescents' routine medical visits is desirable to enhance health behavior discussions. However, the physician should request the parents to leave the room for at least part of the visit to also

specifically allow for adolescent “alone time” with their physician for weight-related discussions.

Acknowledgments

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by grant R01HL092403 from the National Heart, Lung, and Blood Institute.

References

1. Elster AB. Comparison of recommendations for adolescent clinical preventive services developed by national organizations. *Arch Pediatr Adolesc Med.* 1998; 152:193–198. [PubMed: 9491048]
2. Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. *N Engl J Med.* 1997; 337:869–873. [PubMed: 9302300]
3. Bravender T, Tulskey JA, Farrell D, et al. Teen CHAT: Development and utilization of a web-based intervention to improve physician communication with adolescents about healthy weight. *Patient Educ Couns.* 2013; 93:525–531. [PubMed: 24021419]
4. Harrell, FE. *Regression Modeling Strategies: With Applications to Linear Models, Logistic Regression, and Survival Analysis.* New York, NY: Springer;
5. Tates K, Elbers E, Meeuwesen L, Bensing J. Doctor–parent–child relationships: a ‘pas de trois’. *Patient Educ Couns.* 2002; 48:5–14. [PubMed: 12220745]
6. Brown JD, Wissow LS. Discussion of sensitive health topics with youth during primary care visits: relationship to youth perceptions of care. *J Adolesc Health.* 2009; 44:48–54. [PubMed: 19101458]
7. Helitzer DL, Sussman AL, de Hernandez BU, Kong AS. The “ins” and “outs” of provider-parent communication: perspectives from adolescent primary care providers on challenges to forging alliances to reduce adolescent risk. *J Adolesc Health.* 2011; 48:404–409. [PubMed: 21402271]

Table 1

Sample Characteristics.

<i>Patients (N = 183)</i>	
Race (missing 1), % (n)	
White	41 (74)
Non-white	59 (108)
Gender, % (n)	
Female	55 (101)
Male	45 (82)
Age (years), % (n)	
12–13	37 (67)
14–15	30 (55)
16–18	33 (61)
Parental presence, % (n)	
Parent not present for entire visit	20 (37)
Parent present for part of visit	54 (98)
Parent present for the entire visit	26 (48)
Body mass index percentile, mean (SD)	94.6 (3.9)
<i>Physicians (N = 49)</i>	
Race, % (n)	
White	84 (41)
Non-white	16 (8)
Gender, % (n)	
Female	65 (32)
Male	35 (17)
Specialty	
Pediatrics, % (n)	82 (40)
Family medicine, % (n)	18 (9)
Years since medical school, mean (SD)	11.8 (8.7)

Table 2

Generalized Linear Mixed Model Results^a of Association Between Parental Presence and Discussion of Weight-Related Topics (Adjusted for Adolescent Age, Gender, and Race).

Weight-Related Topic	Parent Not Present at All During Encounter ^b (n = 37); Odds Ratio (95% CI)	Parent Present for Part of the Encounter (n = 97) ^b ; Odds Ratio (95% CI)	P ^c
Weight	1.2 (0.3–5.2)	3.6 (1.2–10.9)	.03
Diet	0.7 (0.1–3.0)	2.4 (0.7–7.6)	.12
Physical activity	0.5 (0.1–3.3)	1.2 (0.3–4.3)	.49
Screen time	1.7 (0.7–4.1)	1.1 (0.5–2.6)	.45
Sleep	0.6 (0.2–1.6)	0.9 (0.4–1.8)	.57
Breakfast	1.2(0.4–3.7)	1.2 (0.5–3.2)	.92
Fast food	0.5 (0.1–1.9)	0.8 (0.3–2.0)	.55

^a Analysis includes the 182 physician–adolescent encounters without missing data for any covariate.

^b The reference group is parent present throughout the entire encounter (n = 48).

^c Type III score statistics (χ^2 with 2 degrees of freedom).