

Adolescents consulting a GP accompanied by a third party: comparative analysis of representations and how they evolve through consultation

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Background. Adolescents are frequently accompanied by a third party in consultation. Their stated reason for consulting is rarely psychological. However, many adolescents experience distress or impaired well-being that practitioners fail to detect.

Objectives. To study the ability of adolescents to express personal concerns in general medicine consultations depending on if an accompanier is present and to explore perceptions of participants and how they evolved.

Methods. Six hundred and seventy-four adolescent consultations with 53 GPs were studied. The adolescents and any persons accompanying completed self-administered questionnaires before and after the consultation, the GPs only afterwards. Analyses compared responses before and after consultation and between participants.

Results. Six per cent of the adolescents were consulting for a psychological reason, but, among the others, 17% reported having personal concerns they would like to talk about. Among adolescents aged 14–17 years, those consulting alone more frequently reported personal worries but were more satisfied with the consultation than the others. A third party's presence did not appear to hinder expression for those that consulted accompanied. The representations of the third party and practitioner concerning the adolescent differed, although they tended to converge following the consultation: accompaniers overestimated the adolescents' well-being and freedom to talk, while GPs underestimated their well-being, readiness to confide and feelings of being understood.

Conclusions. GPs could be more optimistic about adolescent consultations: their role is viewed more positively than they think, especially by adolescents consulting alone. The majority of adolescents wishing to say something do so, even when an accompanier is present.

Keywords. Adolescent, general practitioner, patient–physician relationship, third party, well-being.

Introduction

Many young people between the ages of 12 and 20 years consulting a GP are accompanied by a third party. However, it is generally considered best practice for adolescents to be able to consult alone since it fosters autonomy and responsibility. Nevertheless, the watchful presence of parents alongside adolescents is likewise considered to be a favourable health factor.¹

Adolescents' feelings about this presence and its influence have not been well documented to date. Studies have centred more on adult consultations, where, as a general rule, a majority of patients prefer to be accompanied when they consult² and view this presence as helping in communication.³ The majority of practitioners (60%) tend to share this opinion⁴ and admit to being influenced by a third party,³ and 69% view the third party as 'interceding' for the

patient.⁴ However, these observations cannot be extrapolated to the period of adolescence, where the presence of a third party in consultation has specific features. It can be thought that while the presence of an accompanier does seem to favour actual recourse to care, it can make the adolescent less likely to confide his personal concerns, this being an aspect to which adolescents are particularly sensitive,⁵ even though 86% of adolescents state that they are satisfied with their last consultation with a GP, whether they were accompanied or not.⁶ Indeed, unconditional guarantee of confidentiality increases the proportion of adolescents feeling ready to broach delicate personal subjects from 39% to 47%.⁷ Adolescents likewise report preferring to consult a GP rather than a paediatrician because they are less likely to be accompanied.⁸ For their part, practitioners report that they feel no reluctance to ask to see an adolescent alone, but they actually do so infrequently. While 91% state that they are willing to receive minors under 16 unaccompanied,⁹ 51% actually do so and only 38% consider that a specific approach is needed.¹⁰ Yet the way they tune their interventions is very important.¹¹

This is a major issue because 10%–25% of adolescents experience some form of distress or impaired well-being, the boundaries of which are not easy to define.^{12,13} In addition, it has been reported that 80% of adolescents experiencing psychological problems¹³ and 60% of adolescents attempting suicide but not followed up by appropriate care¹⁴ had visited their GPs in the previous year. However, only 6%–7% consult a GP for psychological reasons¹⁵ or receive this diagnosis.¹³ The unreported psychological problem is liable to aggravate if undetected.¹⁶

Thus, there are numerous elements that need to be better understood for this age group: can adolescents express their concerns in a consultation setting and do they want to? Is an accompanier a help or a hindrance? Is it the accompanier or the GP that is the most in tune with what the adolescent feels? These major issues are not dealt within the literature.

With the ADOlescents et Conduites à risques (ADOC) group, we have been able to show that detecting impaired well-being, and even a history of suicidal tendencies, is both possible and straightforward in primary health care.^{14,17,18} However, these studies did not explore effects of the presence of an accompanier. Therefore, the SOCRATE study (*Suivi et Observation en Consultation du Ressenti de l'Adolescent, du Thérapeute et de l'Entourage*) set out to assess the influence of the presence of an accompanier on whether or not the adolescent was able to express personal concerns (without assessing their seriousness); it also aimed to explore how gaps in representations of the adolescent's well-being and resources evolved through a normal GP

consultation for the accompanier, the GP and the adolescent.

Methods

Recruitment of practitioners

The investigating physicians were GPs in private practice (the usual setting for GPs in France). These were recruited in two non-contiguous French *départements* (administrative areas). They were selected randomly and matched for age, gender and practice setting. The study provided for inclusion of 60 practitioners. From the date of signed consent, the physicians were to propose participation in the study to all consulting adolescents.

Inclusion of adolescents

Each physician was to consecutively include 10–15 adolescents aged from 12 to 20 years seen in consultation, whether accompanied or not and whatever the reason for consulting. A total of 600 consultations were thus expected, providing a statistical power of at least 90%, to detect a mean difference of at least 5% on a visual analogue scale (VAS). Inclusions took place from April to June 2007. Since populations in the region have a very homogenous profile (foreign and minority groups = 5%), no item for discrimination of cultural artefacts was included.

Questionnaires

The adolescents and any accompaniers completed separate confidential self-administered questionnaires before and immediately after the consultation in the waiting room and the practitioner only afterwards. Thus, each consultation generated at least three completed questionnaires and five if an accompanier was present. Since no scale was suited to our purposes, the self-administered questionnaire was developed by a pluri-disciplinary team comprising GPs, psychiatrists and methodologists. The questionnaire content focused on 'concerns not voiced when stating the motive for consultation' and on real or supposed feelings experienced by the adolescent. There was no exploration of the nature or the intensity of any problem.

The self-administered questionnaires were tested in consultation on 29 adolescents by 10 GPs from the ADOC group and wordings were adapted. Each questionnaire comprised 19 statements at most with closed response options, 7 using multiple-choice response options and 12 using VASs. The VASs were oriented randomly from right or left, and the subject was asked to position him/herself between the two extremes. The level of VAS reliability was tested by a question about music assumed to be unlikely to be affected by the consultation.

Data management

Positioning on the VAS was measured in centimetres to provide values falling between 0 and 100. The questionnaire responses were entered into Epi Info database version 3.1. Data capture reliability was ensured by independent measures implemented by a second operator and by systematic checks of the data entered.

Statistical analyses

The comparability of the adolescents and the physicians between the two départements was checked once inclusion was complete. A descriptive analysis of responses and of any evolution in the views and feelings of the adolescents following the consultation was conducted in each group of accompanied and unaccompanied adolescents. Statistical comparisons between groups used the chi-square test for proportions and the non-parametric Mann–Whitney test for the VAS. The *P*-values presented as statistically significant were confirmed by linear analyses adjusted on age and gender. The significance of any evolution of responses on VAS before and after the consultation was assessed using the non-parametric Wilcoxon test for paired samples. Agreement between responses of the adolescent, the accompanier and the physician was estimated using the kappa coefficient and its 95% confidence interval.

Results

Sample distribution

Agreement to participate was obtained from 69 practitioners, 36 of whom were practising in the *département* of Charente-Maritime (out of 39 contacted) and 33 in the *département* of Vienne (out of 56 contacted). Actual participation occurred for 53 of these physicians (77%) generating the inclusion of 674 consultations. Six subjects under the age of 12 years, and three whose age was not known, were excluded from the analyses. Thus, analyses were conducted on 665 consultations. Inclusion data are summed up in Table 1. VAS response reliability was high: the ‘test’ question on music, unlikely to be affected consultation factors, showed only negligible variations ($P = 0.42$, the mean

deviation being 0.8/100) between before and after the consultation.

Overall, 64% of the adolescents aged 12–20 years were accompanied by a third party, most frequently the mother (80%) and for 10% the father. Very few physicians had the third party leave the room in the course of the consultation (4.4%). The presence or otherwise of a third party was not linked to the adolescent’s gender but very significantly linked to age: 94% of the adolescents aged 12 and 13 years were accompanied compared to 28% of those aged 18–20 years. Therefore, to discriminate the influence of being accompanied in the 14–17 age group ($n = 344$), two sub-groups were formed: one comprising ‘accompanied adolescents’ (69%) and the other ‘non-accompanied adolescents’ (31%). The data are collated in Table 2, where the values presented as statistically significant have been confirmed by analyses adjusted on age and gender.

‘Before the consultation’, instances where the reason was stated to be ‘psychological’ were few, at 6%, twice as frequent in girls (8%) as in boys (4%). This did not vary according to presence or otherwise of an accompanier. Two-thirds of the adolescents (66%) stated that it was they who had decided to consult. This proportion was higher among the older adolescents, among girls and among those with no accompanier.

Almost all the young people were consulting for a somatic complaint or for administrative reasons (93%, $n = 621$); among these, however, 17% ($n = 106$) reported, before the consultation, the existence of personal worries other than those that led them to consult. This proportion was considerably higher in the 14–17 year age group consulting alone than among those that were accompanied (25% versus 11%) ($P = 0.001$). The majority of the adolescents reporting worries envisaged the possibility of talking about them in the consultation (60%, $n = 64$) and 80% of these did so ($n = 51$). Thus, about half of the adolescents with worries were able to express them (51/106). In addition, adolescents without any ‘psychological reason’ for consulting more frequently mentioned the existence of other worries after the consultation than before (17% versus 26%, $P < 0.001$) whether or not they were accompanied.

‘After the consultation’, the means for satisfaction reported by the young people evolved significantly and positively. Irrespective of whether they were accompanied, the mean value of VAS-rated satisfaction was 87 (SD = 18).

But this evolution was most marked for the 14–17 age group consulting alone. Before consultation, they less frequently felt that people understood them than those who attended accompanied (69/61) ($P < 0.005$), but after the consultation, they felt that better understood than those that were accompanied (13/23) ($P < 0.001$). After the consultation, the physicians were more pessimistic than the adolescents on these

TABLE 1 Participation and inclusion data

Physicians contacted (<i>N</i>)	95
Physicians that signed agreement to participate (<i>n</i>)	69
Physicians that conducted at least 10 consultations (<i>n</i>)	53
Gender ratio of physicians (% men/% women)	68/32
Adolescent consultations (<i>N</i>)	665
Gender ratio of adolescents (% boys/% girls)	41/59
Age of adolescents (mean ± SD)	16.0 ± 2.4
Consultations with third party present (<i>n</i>)	428
Exploitable questionnaires (<i>N</i>)	2851

TABLE 2 Feelings of the young people after consultation and discrepancies with representations of the physician

a. Qualitative variables	All, N = 665	Accompanied (12–20 years), N = 408	Accompanied (14–17 years), N = 237	Not accompanied (14–17 years), N = 107	P ^a
	n (%)	n (%)	n (%)	n (%)	
Age (years)					
12–13	125 (19)	117 (29)			<0.001
14–15	162 (24)	130 (32)	130 (55)	32 (30)	
16–17	182 (27)	107 (26)	107 (45)	75 (70)	
18–20	196 (29)	54 (13)			
Gender					0.40
Male	229 (41)	160 (39)	98 (41)	49 (46)	
Female	395 (59)	248 (61)	139 (59)	57 (54)	
Before the consultation					
Reason for consultation reported by adolescent					0.95
Administrative	155 (23)	84 (21)	53 (22)	25 (23)	
Physical	466 (70)	297 (73)	169 (72)	75 (70)	
Psychological	42 (6)	25 (6)	14 (6)	7 (7)	
The adolescent reported another concern or worry					0.001
Yes	126 (19)	65 (16)	27 (11)	27 (25)	
After the consultation					
The adolescent reported another worry or concern					0.02
Yes	185 (28)	100 (25)	53 (23)	36 (35)	
And he/she was able to talk about it	140 (76)	69 (69)	38 (72)	31 (86)	0.11
b. VASs	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	P ^a
Before the consultation					
The adolescent feels easy with him/herself	70 (28)	72 (28)	73 (27)	63 (28)	0.01
The adolescent feels he/she is in good health	65 (27)	66 (27)	68 (26)	63 (27)	0.088
The adolescent can talk about his/her worries	63 (27)	63 (28)	63 (27)	59 (27)	0.19
The adolescent has someone to confide in	78 (23)	79 (23)	79 (23)	77 (22)	0.28
The adolescent feels he/she is understood	67 (24)	67 (25)	69 (24)	61 (26)	0.005
Evolution in the course of the consultation ^b					
The adolescent feels easy with him/herself	+3 (19) ^c	+2 (18)	+1 (18)	+4 (15) ^c	0.64
The adolescent feels he/she is in good health	+7 (20) ^c	+6 (21) ^c	+4 (19) ^c	+7 (20) ^c	0.17
The adolescent can talk about his/her worries	+10 (22) ^c	+10 (21) ^c	+10 (22) ^c	+12 (25) ^c	0.66
The adolescent has someone to confide in	+3 (17) ^c	+2 (17)	+1 (15)	+2 (18)	0.26
The adolescent feels he/she is understood	+16 (21) ^c	+15 (22) ^c	+13 (21) ^c	+23 (21) ^c	<0.001
Discrepancies between adolescents and physicians after the consultation ^c					
The adolescent feels easy with him/herself	-9 (27) ^c	-12 (27) ^c	-13 (25) ^c	-4 (30)	0.005
The adolescent feels he/she is in good health	-4 (24) ^c	-4 (25) ^c	-5 (23) ^c	-3 (23)	0.62
The adolescent can talk about his/her worries	+2 (25)	+1 (27)	0 (25)	+5 (22)	0.088
The adolescent has someone to confide in	-5 (22) ^c	-5 (22) ^c	-4 (22) ^c	-5 (23) ^c	0.32
The adolescent feels he/she is understood	-6 (20) ^c	-6 (20) ^c	-7 (21) ^c	-6 (18) ^c	0.45
The physician feels he/she met the expectations of the adolescent	-7 (20) ^c	-7 (21) ^c	-9 (20) ^c	-6 (21) ^c	0.20
The adolescent is satisfied with the consultation	-9 (19) ^c	-9 (21) ^c	-11 (20) ^c	-9 (17) ^c	0.15

Analysis according to presence or not of accompaniment.

^aComparison of accompanied and non-accompanied adolescents in the 14–17 age group. Chi-square test for proportions and non-parametric Mann-Whitney tests for VASs. Statistical significance confirmed by analyses adjusted on age and gender.

^bA positive value for difference in feelings in the adolescent before and after consultation (before–after) means that the adolescent has evolved in a favourable direction. A negative value for the difference between the opinions of the adolescent and those of the physician (physician–adolescent) means that the physician assesses the feelings of the adolescent less favourably than the adolescent him/herself.

^cDifference significant at alpha threshold = 0.05; non-parametric tests for matched series.

issues; however, they were significantly more in agreement with the adolescents consulting alone than with those consulting accompanied and in fairly good agreement with the adolescents on how free they felt to talk about their worries.

Comparisons of representations among the three types of protagonist in the consultation are set out in Table 3 and Figure 1, showing frequent disagreement.

The persons accompanying frequently underestimated the concerns and worries of their adolescents, 34% considered that the adolescent had no worries, while 53% of the adolescents reported that they did have worries; the consultation did not alter the opinions of the accompaniers (34% before and 36% after). At the same time, the accompanying adults significantly overestimated their young people's awkwardness and lack

TABLE 3 Discrepancies and agreements among adolescents, accompanying third parties and physicians after consultation

	Accompanier (1) versus adolescent (2) before the consultation Mean (SD)	Accompanier (1) versus adolescent (2) after the consultation Mean (SD)	Physician (1) versus adolescent (2) after the consultation Mean (SD)	Physician (1) versus accompanier (2) after the consultation Mean (SD)
The adolescent feels easy with him/herself ^a	-9 (32) ^b	-2 (25)	-12 (27) ^b	-11 (26) ^b
The adolescent feels he/she is in good health ^a	3 (28) ^b	3 (23) ^b	-4 (25) ^b	-7 (26) ^b
The adolescent can talk about his/her worries ^a	8 (31) ^b	6 (26) ^b	1 (26)	-6 (24) ^b
The adolescent has someone to confide in ^a	0 (27)	2 (22)	-5 (22) ^b	-6 (22) ^b
The adolescent feels he/she is understood ^a	-2 (27)	1 (20)	-6 (20) ^b	-7 (19) ^b
The adolescent has another concern or worry (1)/(2) ^c	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Yes/Yes	30 (47)	54 (60)	75 (79)	87 (82)
No/Yes	34 (53)	36 (40)	20 (21)	19 (18)
Yes/No	47 (14)	53 (18)	116 (41)	94 (37)
No/No	288 (86)	236 (82)	167 (59)	160 (63)
Kappa [95% CI]	0.30 [0.19–0.42]	0.39 [0.29–0.49]	0.28 [0.20–0.37]	0.37 [0.29–0.46]
Proposed further appointment at end of consultation (1)/(2) ^c		<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Yes/Yes		145 (78)	163 (83)	158 (84)
No/Yes		40 (22)	34 (17)	31 (16)
Yes/No		40 (21)	53 (27)	51 (25)
No/No		153 (79)	147 (73)	149 (75)
Kappa [95% CI]		0.58 [0.49–0.66]	0.56 [0.48–0.64]	0.58 [0.50–0.66]

CI, confidence interval.

^aA negative difference between feelings of two respondents means that the first assesses the feelings of the adolescent less favourably than the second (difference accompanier–adolescent, physician–adolescent, and accompanier–physician).

^bDifference significant at alpha threshold = 0.05; non-parametric test for matched series.

^cEach combination of responses gives first the response given by the person referred to as (1) and then the response provided by the person referred to as (2) in the four columns.

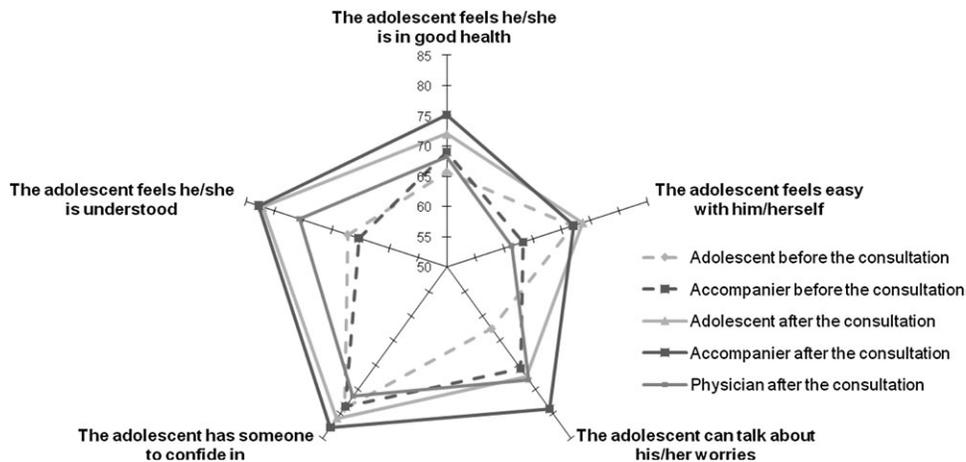


FIGURE 1 Representations of adolescents before and after consultation compared with those of accompanying third parties and physicians. Data are presented as mean values on five VAS

of self-confidence⁹ before the consultation, but they then evolved sufficiently for the difference to be no longer significant afterwards. Both before and after the consultation, however, the accompaniers overestimated the adolescents' feelings of well-being and their freedom to talk about their worries. All agreed that the young people had someone to confide in and felt they were understood.

After the consultation, physicians were significantly more pessimistic than accompaniers regarding most of the feelings they thought were experienced by the adolescents, in particular lack of self-confidence. Unlike the accompaniers, the physicians tended to be in agreement with the young people on their feeling free to talk about their worries. Finally, disagreement was observed among the three types of protagonists on

a fairly objective point: the fact that an appointment was (or was not) made or suggested.

Discussion

These results cast new light on medical consultation among adolescents, according to whether or not a third party is present. Between the ages of 12 and 20 years, one consulting adolescent in every six is experiencing some form of distress or impaired well-being that he/she has not been able to voice. Consultation does enable adolescents to express their concerns if they intend to do so and also leads participants to readjust their representations.

In the 14- to 17-year-old age group in the present study more than a third of the adolescents were accompanied in GP consultation, which did not however prevent most of those with concerns to voice from doing so. Those consulting alone appeared more vulnerable psychologically, but they felt better understood than the others after the consultation. The representations of the different protagonists tend to converge through the consultation, but a distance remains: the accompanying third parties tend to overestimate the well-being of the adolescents and their ability to confide and feel understood.

The distribution of the sample across two matched groups of physicians in two distinct areas consolidates the results. The difference in implication of GPs between the two areas can be attributed to the particular awareness among GPs in one of the two, where the research group has been working and has published results over the last 9 years. However, no significant difference was evidenced in responses to the questionnaire between the two.

The adolescents are subject to a similar bias. Are they representative of adolescents consulting generally?

Most adolescents consult their GP: 74% of the 12- to 18-year-olds.¹⁹ The recruitment of physicians took account of a variety of geographical zones, both urban and rural, and the matching of the two *départements* followed this strategy. While it is difficult to extrapolate to adolescents in general, the quality of the data collection and the numbers of adolescents and accompaniers included do however support the relevance of the analyses.

Score reliability on the VAS (measured by the 'irrelevant' music question) is high, giving increased validity to the differences observed. However, the item relating to other concerns/worries inadequately characterises distress or impaired well-being, even if it certainly approaches it. Nevertheless, the aim was to evidence the existence of concerns other than the reason for consulting and the modes in which the adolescent might broach these issues, without any assessment of severity. Finally, only one consultation by the adolescent was studied, which restricts interpretation.

How far does an adolescent actually wish to express worries and concerns in consultation, and is this setting favourable?

The proportion of 'psychologically motivated' GP consultations evidenced here (6%) is identical to that in other studies.¹⁵ However, the 17% of adolescents reporting worries other than the stated somatic or administrative reasons for consultation fall within ranges reported elsewhere: between 10% and 25% of adolescents have worries or psychological problems, to a degree that is variable according to the severity criteria used.^{11,13} The consultation appeared to help latent problems to surface, no doubt because of the atmosphere of trust established, particularly among adolescents in the 14-17 year age group consulting alone. Either these older adolescents consulting alone had more concerns because they were lacking family support or they felt more free to talk having chosen to come alone: the study did not provide any discriminating element to conclude.

Is the presence of an accompanier a help or a hindrance?

This is an important problem because most studies have shown that adolescents find it easier to broach personal concerns with the physician if they consult alone^{6-10,20,21} and if they are reassured on the strict confidentiality of the encounter.⁷ The third party is thus frequently viewed as preventing adolescents talking freely.

However, our results show that a majority of the adolescents appreciate to be accompanied, whether or not they had worries, and that this opinion did not change following the consultation. Despite this, the study does not enable a conclusion to be reached on this point, firstly because the two adolescent populations could be different and secondly because it is not possible to characterise the 'seriousness' of the 'concerns or worries' mentioned. Our interpretation is that the adolescents consulting alone appeared more likely to be experiencing difficulties that to be quietly autonomous but that they expected (and obtained) more from the GP; in contrast, the adolescents consulting accompanied did not appear to be bothered by a parental presence facilitating the expression of most of their concerns but possibly preventing the most intimate from being broached. Thus, GPs should take account of these new findings to make it easier for adolescents to talk about personal matters.

Is the accompanier or the practitioner better tuned to the feelings of the adolescent?

Before the consultation, the third party, generally the mother, overestimates the adolescent's well-being and ability to talk about personal concerns, but the consultation provides an opportunity for the accompanier to become aware of certain issues. The quality of exchanges is the main factor making this possible.^{12,20,21}

It is the physicians who are the least satisfied with the consultations and the most pessimistic about the adolescents. As underlined in the literature, adolescents trust the physician,⁵ but the present study adds to this finding the fact that physicians underestimate this aspect. Nevertheless, regarding communication, physicians have the same representations as adolescents on their ability to voice worries in consultation. GPs generally think that a third party is a hindrance, while in the present instance, a third party is viewed fairly harmoniously by both accompanied adolescents and accompaniers. GPs also feel closer to the feelings of adolescents consulting alone than to those of accompanied adolescents. These results should encourage them to make better use of these two types of opportunity, in the first instance to provide support and in the second to foster expression. Finally, there is fairly marked disagreement on decisions reached at the end of the consultation (concerning a subsequent appointment). This result suggests that clarification is needed on what occurs at the moment when the protagonists are taking leave. However, the data available does not enable determination of whether the physician or the setting of the consultation is implicated. It can be wondered if the same might not have occurred at the hairdresser's?

Thus, it seems reasonable to reassure physicians: although their feelings about a consultation do not really coincide with those of the consulting persons, the consultation itself has a favourable impact on adolescents (in particular the most vulnerable) and on the understanding that any accompanying third party derives from the encounter. These observations are however restricted to a single consultation, without exploring the severity of the psychological disturbance. Perhaps the short-term pessimism of the physician is a form of lucidity for the longer term? When does the support of a third party become a hindrance to the adolescent feeling free to talk? Only a longitudinal survey can answer such questions.

Declaration

Funding: WYETH Foundation.

Ethical approval: In application of French law, this non-interventional study did not require approval by an ethics committee. The parent or guardian in charge of each participating minor, as well as the minor himself, gave agreement for the study.

Conflicts of interest: none.

Answerability: The Authors, PB, CC, VJ, DM and PI, assume entire responsibility for the content of this study, for the results and for their interpretation.

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