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## **Parental Perceptions of Weight Terminology That Providers Use With Youth**

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# Parental Perceptions of Weight Terminology That Providers Use With Youth



**WHAT'S KNOWN ON THIS SUBJECT:** Language that providers use to describe excess weight can have pejorative connotations, reinforce weight-based stigma, and jeopardize discussions about health with overweight patients. However, few researchers have examined parental perceptions of weight-based terminology in the context of childhood obesity.



**WHAT THIS STUDY ADDS:** In discussions of excess weight with youth, parents prefer that doctors use the terms “weight” and “unhealthy weight” rather than “fat,” “obese,” and “extremely obese.” Parents perceive the latter terms as stigmatizing and blaming and least likely to motivate youth to lose weight.

## abstract

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**OBJECTIVES:** Little research has been performed to examine patient perceptions of weight-related language, especially related to childhood obesity. In this study we assessed parental perceptions of weight-based terminology used by health care providers to describe a child's excess weight and assessed perceived connotations associated with these terms including stigma, blame, and motivation to reduce weight.

**METHODS:** A national sample of American parents with children aged 2 to 18 years ( $N = 445$ ) completed an online survey to assess their perceptions of 10 common terms to describe excess body weight in youth (including “extremely obese,” “high BMI,” “weight problem,” “unhealthy weight,” “weight,” “heavy,” “obese,” “overweight,” “chubby,” and “fat”). Parents were asked to use a 5-point rating scale to indicate how much they perceived each term to be desirable, stigmatizing, blaming, or motivating to lose weight.

**RESULTS:** Regression models revealed that the terms “weight” and “unhealthy weight” were rated as most desirable, and “unhealthy weight” and “weight problem” were rated as the most motivating to lose weight. The terms “fat,” “obese,” and “extremely obese” were rated as the most undesirable, stigmatizing, blaming, and least motivating. Parents' ratings were consistent across sociodemographic variables, body weight, and child's body weight.

**CONCLUSIONS:** The results of this study have important implications for the improvement of health care for youth with obesity; it may be advantageous for health care providers to use or avoid using specific weight-based language during discussions about body weight with families. Pediatricians play a key role in obesity prevention and treatment, but their efforts may be undermined by stigmatizing or offensive language that can hinder important discussions about children's health. *Pediatrics* 2011;128:e786–e793

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### KEY WORDS

obesity, overweight children, parental attitudes, stereotyping, physician-patient/parent communication

### ABBREVIATION

SSI—Survey Sampling International

Dr Puhl conceptualized the project and design, interpreted findings, and led the writing; Ms Peterson reviewed relevant literature, contributed to study measures, managed data collection, and contributed to article drafts and revisions; and Mr Luedicke analyzed the data, interpreted results, created tables, and contributed to writing.

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Youth who are overweight or obese are vulnerable to frequent stigmatization because of their weight.<sup>1–7</sup> Stigmatization poses numerous consequences for youth with obesity, including negative psychological outcomes,<sup>3,8–11</sup> maladaptive eating behaviors,<sup>3,12,13</sup> and avoidance of physical activity.<sup>14,15</sup> There is increasing reason to be concerned about weight stigmatization in the health care setting. Physicians and other health care providers have been documented as common sources of weight bias toward patients with obesity.<sup>16–23</sup> Although parents report that the physician's office is the best place to seek treatment for their child's weight,<sup>24,25</sup> some parents also report feeling blamed by providers for their children's excess weight and being provided with vague advice or unhelpful suggestions.<sup>26,27</sup>

Given providers' attitudes toward patients with obesity, challenges reported by providers in discussing weight, and vulnerabilities of youth with obesity to stigma, it is critical to identify strategies to improve provider-patient discussions about overweight and obesity in youth, and to ensure that these discussions are positive, productive, and free of bias. An important first step in these efforts is to identify appropriate and nonstigmatizing language that providers can use in conversations about weight with youth with obesity and their families.

In 2010, the British public health minister announced that health providers in Britain should call their patients with obesity "fat" to motivate them to lose weight.<sup>28,29</sup> Some research results suggest that the term "fat" is perceived to be pejorative or judgmental, and can increase anxiety and depression in those who are labeled this way.<sup>30</sup> Thus, this type of recommendation from a public health official may reinforce weight-based stigma and interfere with quality of care.<sup>31</sup>

Little research has been performed to examine patient perceptions of weight-related language. Two studies of adults seeking treatment for overweight and obesity revealed that "obese" and "fat" were rated as undesirable terms, and "weight" and "BMI" were preferred.<sup>32,33</sup> Others studies have revealed that "obese" may be perceived as a negative term,<sup>34,35</sup> perhaps because of implications of more serious medical consequences and a sense of confusion it may invoke.<sup>30</sup> Among parents, in 1 qualitative study parents were found to prefer that physicians call their children "overweight" and "obese" instead of more colloquial terms (eg, "chubby" or "plump"),<sup>36</sup> and another reported study "obese" and "fat" were found to be parents' least preferred terms.<sup>24</sup> However, this issue remains poorly understood in the context of childhood obesity. Parental perceptions of specific weight terms, and whether these evoke positive or negative reactions, are issues that have not been quantitatively assessed. In the current study we aimed to examine parents' preferences for terms that doctors use to describe a child's weight, and to assess parents' perceived connotations associated with these terms, including stigma, blame, and motivation to reduce weight.

## METHODS

### Sample and Study Design

The study sample was made up of individuals recruited through a survey panel administered by Survey Sampling International (SSI) during a 1-week period (October 28 to November 2) in 2010. Online recruitment was derived from >3400 sources by use of targeted approaches (eg, banner ads, key words, search links, e-mail, online invitations) to achieve demographic and psychographic diversity within the online population. SSI data aggrega-

tors reach millions of users, carefully screen panelists, and employ validation processes that compare respondent demographic characteristics to multiple databases. SSI provides a variety of incentives (including research feedback, charitable donations, and monetary and points rewards) for participation, which is entirely voluntary. For recruitment onto our study, panelists who identified themselves as parents, and who chose to participate, were directed to the online survey. Of participants who chose to participate, 84% (521) completed the survey. All participants provided informed consent, and the study was approved by the institutional review board at Yale University.

Table 1 lists characteristics of the study participants. Of the initial sample ( $N = 521$ ), 85% of parents reported having a child between the ages of 2 to 18 years. Those with children outside this age range were excluded from analyses, which yielded a final sample of 445 parents. Parents' BMI was stratified by using clinical guidelines for the classification of overweight and obesity in adults by the National Heart, Lung, and Blood Institute of the National Institutes of Health.<sup>37</sup> This stratification revealed that 38% of the parents were normal weight (BMI: 18.5–24.9), 32% were overweight (BMI: 25.0–25.9), and 26% were obese (BMI:  $\geq 30$ ). This distribution of body weight is representative of the general population.<sup>38</sup> For youth, BMI-for-age percentiles were calculated and plotted on the Centers for Disease Control and Prevention 2000 gender-specific growth curves.<sup>39</sup> According to recently established definitions of childhood obesity and overweight, youth with BMI values at the >85th percentile but <95th percentile are considered overweight, and those with a BMI at the >95th percentile are considered obese.<sup>40</sup> The mean score on the Fat

**TABLE 1** Study Participant Characteristics

Gender, <i>n</i> (%)	
Female	263 (59.6)
Male	178 (40.4)
Age, <i>y</i> , <i>n</i> (%)	
18–30	164 (36.9)
31–49	209 (47.1)
50–69	71 (16.0)
Race/ethnicity, <i>n</i> (%)	
White	312 (70.7)
Black	58 (13.2)
Other	71 (16.1)
Weight status (BMI), <i>n</i> (%)	
Underweight (<18.5)	20 (4.5)
Normal weight (18.5–24.9)	169 (38.1)
Overweight (25–29.9)	140 (31.6)
Obese (>29.9)	114 (25.7)
At least 1 overweight child, <i>n</i> (%)	
No	248 (55.7)
Yes	197 (44.3)
Education, <i>n</i> (%)	
High school or less	112 (25.2)
Vocational school/some college	209 (47.1)
College or higher	123 (27.7)
Annual household income, <i>n</i> (%)	
Less than \$25 000	89 (20.1)
\$25 000 to less than \$50 000	161 (36.4)
\$50 000 to less than \$75 000	101 (22.9)
\$75 000 or more	91 (20.6)
Respondents teased, treated unfairly, or discriminated because of weight, <i>n</i> (%)	
No	326 (73.3)
Yes	119 (26.7)
Child teased, treated unfairly, or discriminated because of weight, <i>n</i> (%)	
No	252 (56.6)
Yes	193 (43.4)
No. of children, mean (SD)	1.73 (0.92)
Fat Phobia scale, mean (SD)	3.53 (0.86)

Phobia scale was 3.53, which reflects moderate weight bias and is similar to scores reported for previous research.<sup>21,41,42</sup> The racial distribution of the sample closely resembled that of US Census data, and the household income distribution approximated national percentages.<sup>43,44</sup>

## Measures

### Demographic and Weight Information

Participants reported their age, gender, ethnicity, highest level of education completed, annual household income, height, and weight. Parents were also asked to report their children's age, gender, height, and weight.

### Preferences for Weight Terms

Participants completed a modified questionnaire by Wadden and Didie<sup>53</sup> that read:

Imagine you have brought your child to the doctor for a routine checkup. The nurse has measured your child and found that he/she is significantly above his/her recommended weight. Your doctor will be in shortly to speak with you and your child. You have a good relationship with your doctor, who is committed to the health and well-being of you and your child. Doctors can use different terms to describe body weight. Please indicate how desirable or undesirable you would find each of the following terms if your doctor used it in referring to your child's weight.

Participants rated the following 10 terms (presented in random order) by using a 5-point scale (1, very desirable, to 5, very undesirable) regarding how desirable each term would be if a doctor used it to refer to their weight: extremely obese, high BMI, weight problem, unhealthy weight, weight, heavy, obese, overweight, chubby, and fat. These terms were derived from previous research that reflects commonly used medicalized and colloquial language.<sup>24,33,36</sup> Participants then rated the degree to which they believed each of the 10 weight terms (1) was stigmatizing, (2) blames a child for their weight, and (3) motivates a child to lose weight. All terms were rated on a 5-point scale (eg, 1, not at all stigmatizing, to 5, very stigmatizing), with the midpoint (numerical response 3) interpreted as neutrality in attitudes.

### Reactions to Stigmatizing Language From Providers

Participants were asked: "If your doctor referred to your child's weight in a way that makes you feel stigmatized, how would you react?" On a 5-point scale (1, unlikely, to 5, very likely) participants rated 7 options for how they would react (eg, talk to the doctor, avoid future medical appointments, encourage their child to lose weight).

### Fat Phobia Scale

The Fat Phobia scale<sup>41</sup> was used to assess participants' attitudes about obese persons, expressed by use of 14 pairs of adjectives (eg, "lazy" versus "industrious") on a 5-point scale. Participants selected a point on the scale that best described their feelings about obese persons for each adjective pair. Scores above 2.5 indicate more negative attitudes toward obese people. Cronbach's  $\alpha$  value for this study was .88.

### History of Weight-Based Victimization

Participants were asked 4 forced-choice questions to assess whether they or their child had been teased, treated unfairly, or discriminated against because of their weight.

### Statistical Analysis

Response percentages and mean ratings of the weight-related terms are presented, including 95% confidence intervals. Multiple ordinary least squares regression models were conducted to examine the relationship between demographic characteristics of parents and their children, and parental preferences for weight-based terms. To ease interpretation of coefficients, all 6 variables were *z* standardized. Where appropriate, marginal means, as estimated from the models, are reported with respect to the original scale, to specify the location of differences in means. Latent class analyses<sup>45</sup> for categorical data were conducted to examine different response patterns of items used in the regression models. Analyses were conducted using Stata 11.1 (Stata Corp, College Station, TX) and Mplus 6.1 (Seoul, Korea).

## RESULTS

### Parental Ratings of Weight-Based Terminology

Table 2 lists the mean ratings of all weight-based terms in regard to the

**TABLE 2** Parental Ratings of Weight-Based Terms as Being Desirable, Stigmatizing, Blaming, or Motivating to a Child to Lose Weight

	Full-Item Responses: How Desirable If Used by Doctor?					Mean (95% CI) for Ratings			
	Undesirable		Desirable			How Desirable If Used by Doctor? <sup>a</sup>	How Stigmatizing When Describing a Child's Body Weight? <sup>b</sup>	How Much Does It Blame a Child? <sup>c</sup>	How Much Would It Motivate a Child to Reduce Weight? <sup>d</sup>
	1	2	3	4	5				
Weight	9.4	6.4	25.2	27.2	31.8	3.65 (3.53–3.77)	2.45 (2.34–2.57)	2.36 (2.25–2.48)	3.03 (2.92–3.15)
Unhealthy weight	15.8	10.3	19.3	24.5	30.0	3.42 (3.29–3.56)	2.60 (2.48–2.73)	2.54 (2.41–2.66)	3.60 (3.48–3.72)
High BMI	17.0	9.9	23.4	20.9	28.9	3.35 (3.21–3.48)	2.41 (2.29–2.53)	2.31 (2.19–2.42)	2.89 (2.76–3.03)
Weight problem	20.0	14.5	23.4	22.5	19.5	3.06 (2.93–3.19)	2.93 (2.81–3.05)	2.88 (2.75–3.01)	3.28 (3.16–3.40)
Overweight	20.5	15.9	23.4	20.9	19.3	3.01 (2.88–3.15)	3.04 (2.92–3.17)	2.91 (2.78–3.04)	3.26 (3.14–3.39)
Heavy	26.2	21.4	25.1	17.7	9.7	2.61 (2.49–2.73)	3.31 (3.20–3.43)	2.99 (2.86–3.11)	2.95 (2.83–3.07)
Chubby	42.6	20.7	21.4	7.1	8.1	2.16 (2.04–2.28)	3.53 (3.40–3.65)	3.33 (3.20–3.46)	2.72 (2.59–2.85)
Obese	50.1	15.1	17.4	8.0	9.4	2.11 (1.98–2.24)	3.80 (3.67–3.92)	3.38 (3.24–3.51)	2.79 (2.65–2.94)
Extremely obese	60.6	11.3	14.7	5.3	8.1	1.88 (1.76–2.01)	3.98 (3.86–4.10)	3.55 (3.41–3.69)	2.78 (2.63–2.93)
Fat	60.3	15.8	14.0	4.8	5.0	1.78 (1.67–1.89)	4.01 (3.89–4.13)	3.65 (3.52–3.79)	2.72 (2.57–2.86)

All weight-based terms were rated on a 5-point Likert scale from 1–5.

<sup>a</sup> a1 = Undesirable, 5 = Desirable.

<sup>b</sup> b1 = Not at all stigmatizing, 5 = Very stigmatizing.

<sup>c</sup> c1 = Not at all blaming, 5 = Very blaming.

<sup>d</sup> d1 = Not at all motivating, 5 = Very motivating.

extent that each term was desirable, stigmatizing, blaming, or motivating to their child to lose weight. Full item descriptions are provided for desirability ratings (for other item descriptions, see Supplemental Table 5). Parents rated “weight” as the most desirable term to describe their child’s weight, followed by “unhealthy weight,” “high BMI,” and “weight problem.” The most undesirable terms were “chubby,” “obese,” “extremely obese,” and “fat,” all of which were rated as significantly more undesirable than the remaining 6 terms.

The same pattern of results emerged for parents’ perceptions of the extent to which weight-based terms stigmatize and blame a child for his or her excess weight. Specifically, parents

rated the terms “chubby,” “obese,” “extremely obese,” and “fat,” to be the most stigmatizing and blaming. Terms rated to be the least stigmatizing and blaming were “weight,” “high BMI,” and “unhealthy weight.” Similarly, terms that were rated by parents as most motivating for a child to lose weight were, in order, “unhealthy weight,” “weight problem,” “overweight” and “weight.” The terms rated as least motivating were “chubby,” “obese,” “extremely obese,” and “fat.” Motivational ratings did not differ between participants with or without overweight/obese children. However, analysis of variance results revealed that participants who were overweight and had children with normal weight rated the terms “heavy” ( $F_{2,409} = 2.8$ ;

$P < .05$ ;  $\eta^2 = 0.02$ ) and “overweight” ( $F_{3,410} = 2.9$ ;  $P < .05$ ;  $\eta^2 = 0.02$ ) as more motivating than overweight who were overweight participants with children who were overweight and nonoverweight participants with or without children who were overweight. However, effect sizes were small.

Table 3 lists the parents’ reactions if they perceived their child to be stigmatized about his/her weight by a doctor. There were no significant differences in reactions among parents of children who were overweight/obese versus parents with children who were not overweight. For this reason percentages for the total sample are presented. Although 68% of parents reported that they would react by encouraging their child to lose weight, 50% reported they would request the doctor to use more sensitive language when discussing weight with their child, 37% would feel upset and embarrassed, 36% would put their child on a strict diet, 35% would seek a new provider, and 24% would avoid future medical appointments.

### Latent Class Analysis

In addition to the analysis of mean ratings, a latent class analysis (LCA) for

**TABLE 3** Potential Reactions After Feeling Stigmatized by Child’s Doctor: Percentage of Parents Who Answered “Likely” or “Very Likely”

Reactions	Total (N = 427), % (95% CI)	No Child Is Overweight/Obese (n = 237), % (95% CI)	At Least 1 Child Is Overweight/Obese (n = 190), % (95% CI)
Encourage child to lose weight	68.6 (64.2–73.0)	66.2 (60.2–72.3)	71.6 (65.1–78.1)
Talk to doctor	50.6 (45.8–55.3)	48.5 (42.1–54.9)	53.2 (46.0–60.3)
Be upset/embarrassed	36.8 (32.2–41.4)	36.3 (30.1–42.5)	37.4 (30.4–44.3)
Have my child go on a strict diet	35.8 (31.3–40.4)	33.8 (27.7–39.8)	38.4 (31.4–45.4)
Seek a new doctor	34.7 (30.1–39.2)	33.3 (27.3–39.4)	36.3 (29.4–43.2)
Avoid future appointments with doctor	23.9 (19.8–27.9)	22.4 (17.0–27.7)	25.8 (19.5–32.1)
Do nothing	14.1 (10.7–17.4)	15.2 (10.6–19.8)	12.6 (7.9–17.4)

There was no significant difference between the group of parents who had at least 1 overweight/obese child and parents who did not (Pearson  $\chi^2$ ,  $P < .05$ ). CI indicates confidence interval.

**TABLE 4** Linear Regression Results for Desirability Ratings of Weight-Based Terms According to Parent Demographic Characteristics, Weight Status, History of Weight Stigmatization, and Antifat Attitudes

	Extremely Obese	Fat	Weight Problem	Overweight	Unhealthy Weight	Weight
Gender						
Male	-0.033	0.014	-0.021	-0.170	-0.099	0.048
Age (reference: 18–30 y), y						
31–55	-0.016	0.081	0.092	0.022	0.056	-0.072
56–88	-0.031	0.010	-0.156	-0.103	-0.260	-0.460 <sup>a</sup>
Race/ethnicity (reference: white)						
Black	0.167	0.345 <sup>b</sup>	0.072	0.072	0.109	0.211
Other	-0.016	0.066	-0.100	-0.036	-0.047	0.130
Weight status (BMI) (reference: normal weight)						
Underweight (<18.5)	-0.271	-0.131	-0.398	0.041	0.108	0.052
Overweight (25–29.9)	-0.049	0.110	-0.100	0.126	0.175	0.204 <sup>c</sup>
Obese (>29.9)	-0.041	0.040	-0.134	0.021	0.175	0.133
At least 1 child overweight/obese	-0.079	0.020	0.125	-0.015	-0.033	-0.196 <sup>c</sup>
Children’s gender (reference: all female)						
Mixed, male and female	-0.077	-0.147	-0.078	-0.021	0.020	0.003
All male	-0.001	-0.128	0.038	0.185	0.096	-0.040
Children’s average age	0.012	0.019 <sup>b</sup>	0.040 <sup>d</sup>	0.014	0.009	0.003
Education (reference: high school or less)						
Vocational school/some college	-0.057	0.038	-0.031	0.025	-0.011	0.169
College or higher	0.020	0.065	-0.185	0.112	0.095	0.168
Annual household income (reference: less than \$25 000)						
\$25 000 to less than \$50 000	-0.179	-0.312 <sup>b</sup>	-0.114	0.053	0.026	-0.162
\$50 000 to less than \$75 000	-0.180	-0.182	-0.016	-0.184	-0.189	-0.083
\$75 000 or more	-0.108	-0.225	-0.065	-0.256	-0.397 <sup>b</sup>	-0.193
Respondents teased, treated unfairly, or discriminated because of weight						
Yes	-0.073	-0.200 <sup>c</sup>	-0.203	0.055	0.049	-0.046
Child teased, treated unfairly, or discriminated because of weight						
Yes	-0.053	-0.068	0.050	-0.012	-0.057	-0.030
Fat Phobia scale	-0.066	-0.092 <sup>c</sup>	-0.011	0.057	0.093 <sup>c</sup>	0.058
Constant	0.143	-0.058	-0.262	-0.186	-0.066	0.002
N	411	411	411	411	411	411

Data were compared to ordered logit models and yielded the same results. Linear models are presented to facilitate clearer presentation and interpretation of mean ratings.

<sup>a</sup>  $P < .01$ .

<sup>b</sup>  $P < .05$ .

<sup>c</sup>  $P < .1$ .

<sup>d</sup>  $P < .001$ .

categorical data were conducted to explore possible latent response patterns across desirability ratings (Supplemental Fig 1). The items use the same dependent variables as in the regression analyses reported below, and include 6 of the original 10 weight-based terms: 2 terms that were rated, on average, as most undesirable (“extremely obese,” “fat”); 2 terms that were rated as most desirable (“weight,” “unhealthy weight”), and 2 terms that were closest to neutral ratings (“weight problem,” “overweight”). The LCA revealed 4 qualitatively different response patterns.<sup>46</sup> However, those response patterns (ie, latent

classes) did not differ in their demographic composition with respect to our observed covariates, as we determined by using a multinomial logistic regression.

### Regression Analyses

Regression results are listed in Table 4. No significant differences among participants’ gender or weight status was observed. One age effect emerged, which indicated that older parents (aged  $\geq 50$  years) rated the term “weight” as less desirable (predicted mean value: 3.80, original scale) than younger parents (aged 18–30 years) (predicted mean value: 3.22), which

amounted to almost half of an SD. In addition, the terms “fat” and “weight problem” were rated by parents as slightly more desirable with increasing age of their children. Finally, black parents rated the term “fat” as less undesirable than did white parents, which corresponded to a difference of approximately one-third of an SD. No other patterns were observed across other demographic characteristics.

Similar regression models were estimated to examine parents’ perceptions of weight-based terms as stigmatizing, blaming, or motivating for a child to lose weight. Overall, the pat-

tern of results remained consistent across sample characteristics, with several exceptions. First, parents who had experienced weight-based stigmatization rated 8 of the 10 weight-based terms as more stigmatizing (with the exceptions of “high BMI” and “weight”) compared with those who did not report such experiences, and also considered 4 terms to be more blaming of children (“extremely obese,” “high BMI,” “obese,” and “overweight”). Second, compared with parents with no children who were overweight/obese, parents with at least 1 child who was overweight/obese perceived the terms “unhealthy weight,” “heavy,” and “overweight” to be less motivating for weight loss. Third, parents who endorsed antifat attitudes rated the terms “extremely obese,” “obese,” “chubby,” and “fat” as more stigmatizing and blaming of children compared with parents with more favorable attitudes. All effects pertaining to the Fat Phobia Scale ranged between 13% and 23% of an SD in the ratings for a 1-SD difference in the Fat Phobia scale. Finally, 4 terms (“heavy,” “obese,” “chubby,” and “fat”) were rated as less stigmatizing with increasing age of the parents’ children. The coefficients ranged from 2% to 4% of an SD in ratings per increasing year in children’s age. The term “fat” was rated as less stigmatizing by black parents compared with white parents, which corresponds to a difference of approximately one-third of an SD. All of these effects were statistically significant at the 95% level.

## DISCUSSION

This study was the first, to our knowledge, to systematically assess parental perceptions of weight-based terminology to describe excess weight in youth. Findings show that most parents rated “weight” and “unhealthy weight” to be the preferred terms for doctors to describe their child’s ex-

cess weight, and that “fat,” “extremely obese,” and “obese” were the least desirable terms. These findings were similar to preferences documented among treatment-seeking adults with overweight and obesity.<sup>32,33</sup> Our findings remained consistent across sociodemographic variables, including gender, race, income, education, and parent and child’s body weight. The age effects observed indicate the need for additional research to clarify whether preferences of weight-based language shift as parents (and their children) become older.

Our findings indicate that the terms “fat,” “extremely obese,” and “obese” are perceived by many parents to be the most stigmatizing and blaming terms, and the least motivating terms to encourage weight loss. These findings challenge recommendations made by the British public health minister who encouraged health care providers to call their patients “fat” to instill sufficient motivation to lose weight.<sup>28,29</sup> Instead, most parents in this study reported that the terms “unhealthy weight,” “weight problem,” or “overweight” to be most motivating for weight loss.

In response to weight stigmatization by providers, our findings suggest that parents may react in ways that could have harmful implications for children’s health. Thirty-six percent of parents reported they would put their child on a strict diet in response to weight stigma from a provider. This finding is cause for concern in light of increasing research results that document the health consequences and futility of severe calorie restriction and strict dieting in efforts to achieve long-term, significant weight loss.<sup>47–49</sup> Given that 35% of parents would seek a new doctor, and 24% would avoid future medical appointments in response to weight stigmatization by providers, it is also possible that health care utiliza-

tion could be adversely affected by perceived weight stigma from doctors.

Our findings have several implications for improving health care for youth with overweight and obesity. Pediatricians play a key role in obesity prevention and treatment, but their efforts may be undermined if they use stigmatizing language that can hinder important discussions about children’s health. The use of weight-based terminology that patients find desirable and motivating, and avoidance of language that patients perceive to be stigmatizing and blaming, is an important first step in the facilitation of positive, productive discussions about health with families. Rather than making assumptions about weight-based language to use with patients, providers should ask parents and children about preferred weight-based terminology they would feel comfortable using in patient-provider discussions. It will also be helpful for providers to recognize families that may have heightened sensitivity to weight-based language, such as parents who themselves have been targets of weight stigmatization. More broadly, careful consideration of weight-based terminology is needed for obesity programs targeting youth, to ensure that the health messages communicated are nonstigmatizing, respectful, and motivating. The use of preferred language may be especially important in motivational interviewing interventions for pediatric obesity to sustain child and parental engagement, and for perceived interventionist empathy, and to increase intrinsic motivation (see Mehlenbeck and Wember<sup>50</sup>). It may be useful for future research to address weight-based language to help identify strategies that motivate health behavior changes among patients who are most in need. Several limitations of our study should be noted. First, parental perceptions were assessed by using hypothetical

scenarios rather than real life situations. Future work should combine quantitative and qualitative research methodologies to allow for in-depth examination of nuanced responses by patients. Second, all data were self-report, including weight and height of participants and their children. Third, although we examined 10 common weight-based terms, this list is not exhaustive and there may be other terminology that should be examined. In addition, although parents reported their intended reactions if a doctor stigmatized their child because of his/her weight, it is important to assess actual patient outcomes to determine if the use of nonstigmatizing language by providers may lead to improved outcomes related to health care utilization, perceived quality of care, or compliance with treatment. Extension of this research in ethnically diverse samples will also be important, especially given high rates of childhood obesity in ethnic minorities.<sup>51</sup> Finally, although our sample approximates national demographics, lack of random sampling or sample bias may limit generalizability to individuals who have the time, resources, and Internet access to participate in online surveys. However, the Internet may be more effective for surveys than are telephones,<sup>52,53</sup> and similar studies have published data from the SSI panel.<sup>42,54,55</sup>

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## CONCLUSIONS

The rising numbers of youth with obesity and their vulnerability to victimiza-

tion underscore the need for effective and compassionate health care for this population. Although prevention and treatment of childhood obesity pose numerous challenges for health providers, patient-provider discussions about weight should not be among these obstacles. By using weight-based language that families find supportive and motivating, and avoiding labels that instill stigma and shame, providers can help empower families in their efforts to improve health.

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## Parental Perceptions of Weight Terminology That Providers Use With Youth

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