

Adolescent preferences for weight terminology used by health care providers

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Summary

Background: In light of high rates of obesity and weight stigma in youth, the American Academy of Paediatrics recommends that paediatric health care professionals use appropriate, sensitive and non-stigmatizing language in communication about weight with youth. For these efforts to be effective, there is a need to identify weight-based language preferences among youth with overweight and obesity, as research in this area is scarce.

Objectives: The present study provides a systematic assessment of youth perspectives of weight-based language used by providers.

Methods: Adolescents (ages 13–18 years; $N = 148$) enrolled in a national weight loss camp were surveyed about their preferences for words that health providers use to refer to their body weight. Adolescents completed an online survey and responded to a list of 16 words describing excess body weight, as well as questions assessing demographics, body mass index, and experienced as well as internalized weight stigma.

Results: Adolescents assigned low ratings to words like ‘fat’, ‘large’, ‘obese’ and ‘extremely obese’, indicating that they would not want providers to use these words when discussing their body weight. In contrast, words like ‘weight problem’, ‘BMI’ and ‘plus size’ were rated among the most preferred words for providers to use. Word preferences varied across gender, body mass index and extent of internalized weight stigma.

Conclusions: These findings underscore the importance of acknowledging different word preferences among youth, and to avoid making assumptions about what words youth will feel most comfortable using in discussions about their body weight.

Keywords: Adolescent, language, obesity, patient-provider communication, stigma, terminology.

Introduction

National rates of obesity in American youth remain high (1), and health care providers are increasingly notifying youth of their unhealthy weight status (2). The importance of patient-provider communication about weight-related health has received attention as a key clinical skill for effective obesity intervention and treatment (3), and experts have called for increased research to examine barriers in provider communication to identify strategies that better support and motivate families towards healthier lifestyles (4). Although some research has examined ways for clinicians to improve communication about obesity with youth, this work has primarily focused on clinical approaches

like motivational interviewing (5) or parental perspectives of provider communication (6–8) rather than youths’ viewpoints of provider communication about obesity. As a result, little is known about youth perspectives regarding how doctors talk to them about their weight. This gap in research is concerning, especially in light of evidence that youth with obesity are frequent targets of weight-based bullying (9,10), and are vulnerable to internalizing negative stigma and engaging in self-blame for their weight, which is linked to adverse health (11,12).

A fundamental component of communication about weight is terminology that providers use to describe and discuss a child’s weight status. A 2017 policy statement published by the American Academy of

Paediatrics ('Stigma Experienced by Children and Adolescents with Obesity') recommends that paediatric health care professionals use sensitive and non-stigmatizing language when discussing weight with youth (13). Although limited qualitative evidence suggests that parents and youth are generally supportive of health providers discussing youth weight status (14), there is an absence of research assessing specific weight-based terminology preferences among youth with obesity. This is a clear priority for research, especially given research studies in adults documenting weight stigmatizing attitudes and behaviours of health care providers (15), and poor rapport between providers and patients with obesity (16).

Thus, it is important to identify weight-based language and terminology that youth view to be supportive and motivating, versus language that youth perceive as stigmatizing, blaming or judgmental. Studies assessing patient preferences for weight-based terminology have almost exclusively examined adults, which consistently demonstrate preferences for weight-neutral language (e.g. 'unhealthy weight' or 'body mass index') rather than 'obesity', 'fat' or other weight descriptors (17–20). To date, only one study has systematically assessed youth preferences for weight-based language in the context of parental communication at home, showing that youth preferred parents to use neutral terminology (like 'weight' and 'body mass index'), while words like 'fat' and 'obese' induced feelings of sadness, embarrassment and shame (21). No research has assessed youth perceptions of weight-based language from health care providers. The present study provides an initial step to address this research gap through a systematic assessment of perspectives of weight-based language used by providers among a treatment-seeking sample of adolescents with overweight and obesity. We examined adolescent preferences for weight-based terminology from providers, and variation in preferences by adolescent gender, body weight and internalized stigma.

Methods

Participants

Participants were 148 adolescents enrolled in a national, summer, commercial weight-loss camp (Camp Shane) in 2017. The camp requires a documented medical history and physician's appointment for all campers to attend the program. At camp registration, parental consent was obtained for adolescents ages 13–18 years old to complete an optional online questionnaire. Of the 459 campers enrolled in the 2017 summer camp session, 306 were in the eligible age-

range (13–18 years) to complete the survey, of which 48.4% completed the survey. Consenting parents were provided with the survey weblink to share with their child to complete the survey. Participation was voluntary, and adolescents received a gift card to an online retailer following completion of the survey. The study was approved by the authors' university institutional review board. Adolescents who enrolled in the study relative to the total camp population were slightly older (age of all eligible campers: $M = 15.26$, $SD = 1.63$; age of campers enrolled in study: $M = 15.97$ $SD = 1.25$), and more male adolescents (74 of 100) completed the survey than female adolescents (74 of 206).

Procedure and measures

Data collection occurred between April and July 2017. Participants at all camp locations (Arizona, California, Georgia, New York, Texas, Wisconsin) with parental consent were invited to complete the online survey anonymously and in a private setting (e.g. at home) prior to or after attending camp. After providing assent, participants entered the survey website (hosted by *Qualtrics.com*) and completed demographic (age, gender, race) and anthropometric (current height and weight) questions, followed by two yes/no questions about whether they had been teased or bullied about their weight by peers, and whether they had been teased or treated unkindly because of their weight by family members. Body mass index (BMI) percentiles (<85th, 85–95th and >95th) for age and sex were calculated and categorized using calculation tools provided by the Centers for Disease Control and Prevention (22).

To assess preferences for weight-based language from health care providers, adolescents were asked to respond to a list of 16 words describing excess body weight (see Tables 1–3). This measure was developed and tested previously by the authors; (21) items were derived from previous research on weight-based terminology preferences in adults (17), and revised through consultation with clinical experts treating youth in paediatric obesity treatment programs. Participants were asked 'Which words would you most want health care providers (e.g., a doctor, nurse, or nutritionist) to use to talk about your weight?' Participants rated each word on a 5-point Likert scale (1 = 'No, please never use this word', 2 = 'This is not a good word choice', 3 = 'Not sure', 4 = 'This word is okay to use', 5 = 'Yes, I prefer you use this word'), with higher ratings indicative of stronger preferences for health care providers to use the word.

Table 1 Adolescent preferences for weight-based terminology from health providers

Word	M	SD	% Adolescents who do not like this word	% Adolescents unsure about this word	% Adolescents who prefer this word
Weight problem	3.63	1.14	18.9	23	58.1
Plus size	3.47	0.88	14.9	27.7	57.4
Chubby	3.45	0.93	14.9	29.1	56.1
BMI	3.34	0.92	18.2	33.8	48
Weight	3.34	1.18	28.4	24.3	47.3
High BMI	3.24	1.07	28.4	27.7	43.9
Higher body weight	3.22	0.94	23.6	35.8	40.5
Unhealthy weight	3.21	1.20	30.4	20.9	48.6
Overweight	3.05	1.05	37.8	22.3	39.9
Big	2.93	1.03	33.1	37.8	28.4
Heavy	2.91	0.95	42.6	26.4	31.1
Fat	2.78	1.17	43.2	27	29.7
Large	2.77	0.87	42.6	36.5	20.9
Curvy	2.66	1.04	44.6	30.4	24.3
Obese	2.62	1.26	44.6	24.3	31.1
Extremely obese	2.34	1.28	54.7	18.9	26.4

Note: Participants rated each word on a 5-point Likert scale (from 1 = 'No, please never use this word' to 5 = 'Yes, I prefer you use this word'), with higher ratings indicative of stronger preferences for health care providers to use the word.

Table 2 Word preferences according to adolescents' BMI category

Word	BMI percentile <85		BMI percentile 85–95		BMI percentile >95		df	F	P
	M	SD	M	SD	M	SD			
Overweight	3.05 ^a	1.03	3.51 ^b	0.96	2.55 ^c	0.94	2, 147	12.79	<.001
Higher body weight	3.19 ^{ab}	0.80	3.53 ^a	0.90	2.92 ^b	1.00	2, 147	5.91	.003
Weight problem	3.05 ^a	0.76	3.27 ^a	1.19	4.49 ^b	0.78	2, 147	32.51	<.001
Unhealthy weight	2.88 ^a	1.06	2.64 ^a	1.13	4.10 ^b	0.83	2, 147	30.46	<.001
Weight	3.57 ^a	1.11	3.60 ^a	1.20	2.86 ^b	1.08	2, 147	6.87	.001
Heavy	3.36 ^a	0.79	2.93 ^b	0.90	2.53 ^b	0.97	2, 147	9.87	<.001
Obese	3.02 ^a	0.87	3.15 ^a	1.04	1.73 ^b	1.28	2, 147	26.49	<.001
Chubby	3.19 ^a	0.86	3.29 ^a	0.99	3.82 ^b	0.79	2, 147	7.13	.001
Fat	2.83 ^a	0.88	3.22 ^a	1.13	2.25 ^b	1.21	2, 147	10.26	<.001
Extremely obese	3.05 ^a	0.99	2.55 ^b	1.15	1.53 ^c	1.21	2, 147	22.37	<.001
Large	2.95 ^a	0.73	2.98 ^a	0.93	2.39 ^b	0.78	2, 147	8.16	<.001
Plus size	3.31 ^a	0.95	3.15 ^a	0.85	3.96 ^b	0.60	2, 147	14.82	<.001
Curvy	3.10 ^a	0.73	2.87 ^a	0.93	2.08 ^b	1.11	2, 146	15.35	<.001
Big	3.17	1.06	2.80	1.05	2.88	0.95	2, 146	1.65	.196
BMI	3.29	0.94	3.38	1.01	3.35	0.82	2, 147	0.13	.878
High BMI	3.05	0.79	3.51	0.98	3.12	1.29	2, 147	2.84	.062

Note. Superscript letters (a, b, c) indicate significant differences in means between groups within a given row; these reflect least squared difference post-hoc tests where differences are $P < .05$. For example, preference for the word 'overweight' differs between all three groups as indicated by superscript 'abc'. Preference for the word 'higher body weight' differs between adolescents with a 'BMI percentile 85–95' and those with a 'BMI percentile >95', but ratings of 'high body weight' are not significantly different between adolescents with 'BMI < 85' and those with a 'BMI of >95'. Only 'higher body weight' does not pass the Bonferroni correction for conducting 48 tests, which requires a $P < .001$.

To examine the association between word preferences for body weight and adolescents' internalized weight stigma, they completed the modified version of the Weight Bias Internalization Scale (WBIS-M)

(23,24). This measure has been used in adolescent treatment-seeking samples (11), and assesses the extent to which people blame themselves for weight stigma, apply negative weight-based stereotypes to

Table 3 Word preferences according to adolescents' level of weight bias internalization (WBI)

Word	Low WBI (1 SD below mean)		Mean WBI		High WBI (1 SD above mean)		df	F	P
	M	SD	M	SD	M	SD			
Overweight	3.25	1.06	3.03	0.99	3.00	1.31	2, 147	0.34	.715
Higher Body Weight	3.00	0.97	3.25	0.86	3.26	1.25	2, 147	0.50	.605
Weight Problem	3.38 ^a	0.81	3.55 ^b	1.19	4.17 ^b	0.94	2, 147	3.40	.036
Unhealthy Weight	2.94	0.93	3.26	1.14	3.17	1.61	2, 147	0.50	.607
Weight	3.63	1.31	3.27	1.18	3.48	1.08	2, 147	0.84	.433
Heavy	3.38 ^a	0.96	2.93 ^b	0.96	2.52 ^b	0.73	2, 147	4.04	.020
Obese	2.88	0.81	2.61	1.28	2.48	1.44	2, 147	0.47	.627
Chubby	3.31	0.60	3.44	0.96	3.57	0.99	2, 147	0.35	.702
Fat	2.56	1.21	2.79	1.08	2.87	1.52	2, 147	0.35	.708
Extremely Obese	2.81 ^a	1.22	2.46 ^b	1.24	1.43 ^c	1.16	2, 147	8.00	.001
Large	3.00 ^a	0.52	2.85 ^a	0.88	2.22 ^b	0.80	2, 147	6.16	.003
Plus Size	3.38	0.72	3.48	0.90	3.52	0.90	2, 147	0.14	.874
Curvy	3.19 ^a	0.66	2.78 ^a	1.01	1.74 ^b	0.86	2, 146	13.93	< .001
Big	3.06 ^a	0.93	3.02 ^a	1.03	2.43 ^b	0.95	2, 146	3.32	.039
BMI	3.50	0.97	3.27	0.93	3.61	0.84	2, 147	1.57	.211
High BMI	3.25	0.77	3.12 ^a	1.08	3.83 ^b	1.03	2, 147	4.36	.014

Note. Superscript letters (a, b, c) indicate significant differences in means between groups within a given row; these reflect least squared difference post-hoc tests where differences are $P < .05$. For example, preference for the word 'weight problem' differs between adolescents in the low WBI group and those in the mean WBI group and the high WBI group. However, adolescents in the mean WBI group and the high WBI group do not significantly differ in their preference for 'weight problem'. 'Weight problem', 'heavy', 'large', 'big' and 'high BMI' do not pass the Bonferroni correction for conducting 48 tests, which requires a $P < .001$.

themselves, and judge themselves negatively due to their weight. Participants responded to 10 items on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*) ($\alpha = .84$); responses were summed and averaged to calculate mean scale scores. To assess differences in word preferences according to level of internalized stigma, we examined adolescents who scored (i) one standard deviation below the mean on the WBIS-M (low internalization), (ii) within one standard deviation of the mean on the WBIS-M and (iii) one standard deviation above the mean on the WBIS-M (high internalization).

Statistical analysis

All analyses were conducted using SPSS version 22.0. Gender differences for word preferences were tested using a series of independent t-tests. A series of one-way ANOVAs compared word preferences by BMI categories (based on percentiles for age and sex: <85 percentile, 85–95th percentile, >95th percentile) and internalized weight stigma (low internalization or one SD below the mean, mean internalization, and high internalization or one SD above the mean). Least squared difference post-hoc tests determined precise differences among the three means when each one-way ANOVA yielded a

significant F statistic. The Bonferroni correction for conducting multiple tests suggests $P < .001$ for 48 tests. We note where a significance test does not pass this correction below.

Results

Of the total sample ($N = 148$), 50% were girls and 50% were boys, and the average age was 15.97 years ($SD = 1.25$). Among participants, 90.5% were White, 4.7% Hispanic/Latino, 2.7% Asian and 2.0% Black. The average BMI percentile of participants was 27.06 ($SD = 4.39$); 34.5% of participants had a BMI in the obese range and 37.2% had an overweight BMI. As some of the campers experienced significant weight loss and returned to camp for weight loss maintenance, 28.4% of participants had achieved a BMI in the healthy weight range. The mean score on the WBIS-M was 5.45 ($SD = 0.88$), suggesting a high level of internalized weight stigma in the total sample. A total of 15.6% of the sample endorsed high levels of internalized stigma 73.6% scored within one standard deviation of the WBIS-M mean, and 10.8% endorsed low levels of internalization. No differences in internalization emerged as a function of gender ($t(146) = 0.62$, $P = .535$), including when controlling for BMI and experienced weight stigma ($F(1,$

143) = 0.66, $P = .418$). Nearly all (93.9%) participants in the sample reported experiencing weight-based bullying from peers and 60.1% experienced being teased or treated unkindly about their weight from family members.

Adolescent preferences for weight terminology

Although all word preferences were rated on a scale of 1 to 5, most means for word preferences occurred near the midpoint of the scale, suggesting that youth may be unsure about which words they feel most comfortable with providers using to talk about their weight. Mean ratings for the total sample are depicted in Table 1. Participants most preferred providers to use words like 'weight problem' ($M = 3.63$, $SD = 1.14$), 'plus size' ($M = 3.47$, $SD = 0.88$), 'chubby' ($M = 3.45$, $SD = 0.93$), 'BMI' ($M = 3.34$, $SD = 0.91$) or 'weight' ($M = 3.34$, $SD = 1.18$) to refer to their body weight in clinical interactions. The least preferred words to describe weight were 'extremely obese' ($M = 2.34$, $SD = 1.28$), 'obese' ($M = 2.62$, $SD = 1.26$), 'curvy' ($M = 2.66$, $SD = 1.04$), 'large' ($M = 2.77$, $SD = 0.87$) and 'fat' ($M = 2.78$, $SD = 1.17$). Several significant gender differences emerged in ratings for word preferences. Girls assigned higher ratings than boys to the following words: 'weight' (girls: $M = 3.58$, $SD = 1.16$; boys: $M = 3.09$, $SD = 1.15$; $t(146) = -2.56$ $P = .011$) 'heavy' (girls: $M = 3.08$, $SD = 1.00$; boys: $M = 2.74$, $SD = 0.86$; $t(146) = -2.20$ $P = .030$) and 'obese' (girls: $M = 2.88$, $SD = 1.13$; boys: $M = 2.36$, $SD = 1.34$; $t(146) = -2.25$, $P = .013$). Boys assigned higher ratings to the word 'unhealthy weight' than girls (boys: $M = 3.50$, $SD = 1.08$; girls: $M = 2.92$, $SD = 1.26$; $t(146) = 3.02$ $P = .003$). None of these differences however passes the Bonferroni correction for conducting multiple tests.

Word preferences according to BMI and internalized stigma

Table 2 displays differences in body weight language preferences as a function of BMI percentiles for age and sex. In most cases, there were no significant differences in word preferences between participants with a BMI below the 85th percentile and those with a BMI between the 85th and 95th percentiles. However, both of these groups were often different in their word preferences compared to adolescents with a BMI above the 95th percentile. Adolescents with a BMI above the 95th percentile expressed a stronger preference for words like 'weight problem', 'unhealthy weight' and 'chubby' than the other two BMI groups,

and expressed less preference for words like 'weight', 'obese' and 'fat' less than the other two BMI groups. The word 'overweight' was most preferred by adolescents with BMI between the 85th and 95th percentile ($M = 3.51$, $SD = 0.96$), followed by adolescents with a BMI under the 85th percentile ($M = 3.05$, $SD = 1.03$), but received lower ratings by adolescents with a BMI above the 95th percentile ($M = 2.55$, $SD = 0.94$). 'Higher body weight' was preferred more by adolescents with a BMI under the 85th percentile ($M = 3.19$, $SD = 0.80$) and between the 85 and 95th percentiles ($M = 3.53$, $SD = 0.90$) compared to those with a BMI above the 95th percentile ($M = 2.95$, $SD = 1.00$); however, this test did not pass the Bonferroni correction.

Table 3 presents word preferences as a function of internalized weight stigma. Adolescents with the highest levels of internalization showed significantly less preference for words like 'large', 'curvy' and 'big' while adolescents with low or mean levels of internalization did not differ from one another in preference for these words. Words like 'weight problem' were more preferred by adolescents at the mean ($M = 3.55$, $SD = 1.19$) or at high levels of internalization ($M = 4.17$, $SD = 0.94$) compared to those at the lowest levels of internalization ($M = 3.38$, $SD = 0.81$). Preferences for 'heavy' differed linearly, being most preferred by adolescents with low internalization ($M = 3.38$, $SD = 0.96$), less preferred among those with mean levels of internalization ($M = 2.96$, $SD = 0.96$) and least preferred by adolescents with high levels of internalization ($M = 2.52$, $SD = 0.73$). 'Weight problem', 'heavy', 'large', 'big' and 'high BMI' do not pass the Bonferroni correction.

Discussion

The present study provides a needed first step to address a considerable gap in research by identifying youth perspectives of weight-based terminology used by health care providers. Findings of this study indicate a higher preference among adolescents for providers to use words like 'weight problem', 'weight', 'BMI' and 'plus size' when referring to their body weight in clinical interactions, compared to words assigned the lowest ratings like 'extremely obese', 'obese', 'large', 'fat' or 'curvy'. These findings are somewhat similar to studies of adult preferences for more neutral weight-based terminology (17–20) and suggest the importance of future research to assess whether use of neutral terminology by providers is related to patient outcomes or treatment adherence.

Unexpectedly, 'chubby' was among the words assigned higher preference ratings in this sample

(although still just above the midpoint of the rating scale); this word has been viewed to be more blaming and less motivating in research assessing word preferences among adults (17), and received low preference ratings in a recent study of adolescent perspectives of parental use of weight-based language (21). Closer examination of the present findings shows that 'chubby' received higher preference ratings in adolescents with a BMI above the 95th percentile compared to those with lower body weight; it may be that for adolescents with obesity, the word 'chubby' connotes a lesser degree of excess weight than obesity and is thus viewed to be less negative or induces less discomfort than words that more clearly indicate obesity. Additional research is warranted to examine youth interpretations of different weight-based terminology and emotional reactions (such as shame, self-blame and comfort-level) associated with these words.

The present findings also indicate variations in word preferences among adolescents according to their gender, BMI and extent of internalized weight stigma. Some of the patterns observed are expected, such as lower ratings of words like 'obese', 'fat', 'large' 'big' or 'heavy' among adolescents with a BMI above the 95th percentile and/or who had high levels of internalized stigma. Because of their higher body weight and self-blame, these adolescents may have heightened sensitivity to words that have negative societal connotations or increase the saliency of their high body weight. On the other hand, it is less intuitive why adolescents with a BMI above the 95th percentile expressed lower ratings for more neutral words like 'weight' and 'higher body weight'. These findings underscore the importance of acknowledging a range of word preferences among youth, and to avoid making assumptions about what words youth will feel most comfortable using in discussions about their body weight. Acknowledging diverse youth preferences and asking each patient '*Could we talk about your weight today?*' and '*What words would you feel most comfortable with as we talk about your weight?*' may help providers ensure that they are communicating in a way that patients view to be respectful, supportive, and less distressing. Furthermore, asking adolescents about their language preferences may help to encourage their autonomy in health-related discussions, which is age appropriate for this developmental period.

It is noteworthy that adolescent ratings of weight-based terminology did not indicate strong preferences for any words, as none of the 16 words received ratings of 4 or higher on the 5-point rating scale in the total sample. Most words received mean

ratings around the mid-point of scale. It may be that all types of conventional weight-based terminology instill some degree of discomfort or uncertainty for youth struggling with weight. Body weight is an emotionally charged issue, especially for youth (25), and it could be that discussions about body weight are perceived to be negative or distressing, regardless of whether or not neutral words are used to refer to their weight. Additionally, it is important to note that this sample of adolescents had considerably high levels of internalized weight stigma. The mean score on the WBIS-M was 5.45, which is higher than means observed on this measure in national general population samples and treatment-seeking samples of adults (26,27), individuals with obesity and binge eating disorder (28) and adolescent patients seeking bariatric surgery (11). Given the high levels of internalized blame and stigma in this sample of adolescents, it is possible that they may have heightened sensitivity to language and communication about their body weight, even for more neutral weight-based terminology. It will be important for future research to better clarify perspectives and reactions to language about weight among vulnerable youth who may be particularly sensitive because of internalized stigma and blame.

Several limitations of this study should be noted. The present sample was composed of primarily White adolescents, and future work should prioritize research with ethnic minority youth. It may be that word preferences vary across certain racial/ethnic groups, as some evidence has demonstrated racial and ethnic variations in body image (29). We did not collect information on parental education or income to assess socioeconomic status because adolescents may not be able to accurately answer these questions. Campers enrolled in these weight loss camps likely have higher socioeconomic markers given the costs associated with attending the camp. Future work should examine preferences in more diverse economic groups. Participants who completed the study were slightly older than those who were eligible to complete the survey but who did not enrol, and a higher proportion of male adolescents completed the survey than female adolescents. Given that adolescents in this study attended a weight loss camp and expressed high levels of internalized stigma, findings may not generalize to broader groups of youth including weight-matched peers participating in other types of weight loss treatment programs; it will be important to examine language preferences in more diverse samples. Furthermore, identifying language preferences in younger children is warranted given high rates of child obesity and the need for discussions about weight-

related health to start early in childhood. Finally, it was beyond the scope of the present study to examine links between language preferences and psychosocial wellbeing; this too warrants research attention to identify whether youth experience distress in response to adults using words about body weight that are perceived to be stigmatizing, judgmental or shaming.

Conclusion

This study offers novel initial insights about youth perspectives for discussions about body weight with medical providers. Using sensitive and non-stigmatizing language is a tangible step that paediatric providers can take to promote positive, productive conversations about weight-related health with youth and families. Our findings suggest that adolescents have different preferences for the words that health care providers use to describe their weight. Although more work is needed to obtain a comprehensive understanding of youth reactions to weight-based terminology, providers can be proactive in their use of appropriate weight-based language, recognizing that language preferences vary in their patients, and asking youth what words they feel most comfortable using to talk about their weight. While obesity treatment is complex and challenging, patient-provider communication should not pose additional barriers to this process; words from providers should help heal, rather than unintentionally harm, youth who are struggling with weight.

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Conflicts of Interest

The authors declare no conflicts of interest.

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