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Motivations for engaging in or avoiding conversations about weight: Adolescent and parent perspectives

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Summary

Background: Little is known about parent and adolescent motivations for engaging in weight communication.

Objectives: To assess parent and adolescent motivations for engaging in, or avoiding, weight communication, and whether these reasons differed across sex, race/ethnicity, weight, and engagement in weight management.

Methods: Independent samples of parents ($N = 1936$) and unrelated adolescents ($N = 2032$) completed questionnaires assessing their agreement with different reasons they engage in, or avoid, parent-adolescent weight communication, using 7-point Likert scales (*strongly-disagree* to *strongly-agree*).

Results: Parents, irrespective of sex, race/ethnicity, and child's weight status, expressed stronger motivations for engaging in weight communication in order for their child to feel good about his/her weight and body size compared to being motivated because a health professional raised their child's weight as a concern. Adolescent motivations for weight communication with parents stemmed from health concerns and worry about their weight; avoidance stemmed from feeling embarrassed, upset, or not wanting to obsess about weight. Differences emerged across sex and race/ethnicity but were most pronounced by weight status and weight management.

Conclusion: Parents and adolescents have different motivations for engaging in or avoiding weight communication. Protecting adolescents' emotional wellbeing and body esteem are viewed as reasons for both engaging in or avoiding weight communication.

KEYWORDS
adolescent, communication, parent, weight-talk

1 | INTRODUCTION

It is common practice for many parents to talk to their children about body weight. Recent estimates of adolescent-reported parental comments about weight are as high as 78%,[1] with somewhat lower ranges reported across different studies, and variation by gender of parents and youth.[2–5] Typically, evidence points to higher levels of parental weight communication with youth who have higher body mass index (BMI).[2,6,7] However, other evidence indicates that parents engage in weight-focused conversations with children across diverse body weights and sizes,[8] suggesting that weight communication occurs in families irrespective of weight status.

To date, the literature on parental weight communication (also referred to as parental 'weight talk') has primarily examined the

frequency and types of comments that parents make about weight to their child, and the implications of parental weight communication for child and adolescent health. Most research has examined negative comments that parents make about their child's body weight or size, including critical remarks, weight teasing, and encouraging their child to lose weight.[9–11] Studies consistently point to links between parent weight-focused communication and adverse outcomes for youth, including unhealthy weight control behaviours, dysfunctional eating patterns, body dissatisfaction, and psychological distress.[12,13] Further, negative health consequences resulting from parental weight communication may persist beyond adolescence into adulthood.[14–17] Much of the literature assessing the consequences of family weight communication reflects data from adolescent reports and observational studies; collectively this evidence has prompted concerns about the harmful impact of parental weight communication on youth and adolescent health.

Comparatively less is known about the motivations and intentions of parental weight communication. Existing studies have focused more on identifying health-related consequences of negative parental weight-talk rather than on attempting to understand the reasons underlying conversations about weight. Surprisingly little research attention has focused on why parents choose to engage in, or avoid, talking about weight with their children. To date, insights about parental motivations come from primarily qualitative evidence.[8,18–22] For example, findings from interviews with primarily Black/African American parents ($N = 47\%$, 90% female) found that parents talked to their child(ren) about weight because of a health professional's concern about their child's health; their own parental concerns; or to 'strengthen their child's skin' so that their child would not be as upset by being teased about their weight from others.[20] Parents who avoided talking about weight did so because they wanted their child(ren) to demonstrate good manners and respect for others (e.g., because of parental views that it is rude to comment on a person's weight), or because of their own previous negative experiences of weight communication from family or friends prompted them to prevent similar experiences for their child. More recent findings from qualitative interviews with mothers ($N = 188$) of children (ages 6–11) suggest a range of motivations for engaging in weight talk with youth, including wanting to promote healthy eating and physical activity; avoiding health complications; concerns about their child's health; prosocial teaching about not teasing others about weight; and building self-esteem.[18] Moreover, recent evidence from 150 ethnically diverse mothers of children (ages 5–7) identified different themes for reasons why parents engaged in weight conversations depending on their child's weight status. Parents of children with overweight or obesity talked about weight because of concerns about their child's weight gain or to teach their child about body weight in a cautionary way (e.g., pointing out the weight gain of other family members).[8] Parents of children without overweight or obesity reported engaging in weight conversations with their child if a health professional had prompted them to do so, or avoided weight talk because of their own prior negative weight experiences in childhood.[8]

Taken together this qualitative evidence suggests that parents may engage in, or avoid, talking to their child about weight for a range of different reasons, some of which may depend on weight-related characteristics of themselves or their child. This body of qualitative work also highlights broader gaps in knowledge. First, little is known about motivations for engaging in weight talk among fathers, and whether motivations for engaging in or avoiding parental weight talk differ for mothers and fathers. Second, limited research has examined the nature of family weight communication across race/ethnicity; some evidence has documented family weight communication to be more common and hurtful among Hispanic/Latinx families than other racial/ethnic groups.[1,17] In qualitative research with Black/African American parents, approximately 2/3 felt that their culture promotes weight talk within the home.[20] However, the nuanced meanings and values that parents of different racial/ethnic backgrounds associate with weight talk are not well understood, and no quantitative work has yet examined how motivations for weight communication may differ for families of different racial/ethnic backgrounds. Understanding these potential differences could inform paediatric providers as they approach conversations about weight-related health with families of diverse backgrounds. Third, no research to our knowledge has assessed adolescent motivations for engaging in or avoiding weight conversations with their parents and how this varies across sex, race/ethnicity, and weight status. Understanding these motivations, from both parent and adolescent perspectives, and across sociodemographic characteristics, is critical to understand the nature of parent–child weight communication in order to help families best navigate weight-related topics.

To begin to address these research gaps, the present study conducted a quantitative examination of parent and adolescent motivations for engaging in, or avoiding, conversations about weight. Using large, diverse, and independent samples of parents and unrelated adolescents with respect to sex, race/ethnicity, and weight status allowed us to investigate and compare how motivations may differ across these groups. We also examined whether internalization of weight bias and adolescent engagement in weight management contributed to their motivations for weight talk.

2 | METHOD

2.1 | Participants and Procedure

This study surveyed a sample of 1936 parents (52% female) residing in the U.S. with children 10–17 years old, and an independent, unrelated U.S. sample of 2032 adolescents (59% female) 10–17 years old. The racial/ethnic distribution of the parent sample is as follows: 33% Black or African American, 32% White, non-Hispanic, non-Latinx, 31% Latinx, Hispanic, or Mexican-American, and 4% another race/ethnicity (e.g., American Indian or Alaskan Native). The racial/ethnic breakdown of the adolescent sample is as follows: 40% White, non-Hispanic, non-Latinx, 25% Black or African American, 23% Latinx, Hispanic, or Mexican-American, 12% of another race/ethnicity. In addition, to sample quotas that were established to ensure approximately equal distributions for sex (i.e., female, male) and race/ethnicity (i.e., Latinx, Hispanic, or Mexican-American; Black or African American; White,

non-Hispanic, non-Latinx), weight status quotas were established (i.e., prevalence specifications for BMI/weight categories) within both samples to approximate national averages. The parent sample was comprised of 6% with BMI < 18.5 kg/m^2, 31% with BMI 18.5–24.9 kg/m^2, 30% with BMI 25–29.9 kg/m^2, and 32% with BMI ≥ 30 kg/m^2. The adolescent sample was comprised of 5% with BMI < 5th percentile, 52% with BMI 5–84.9th percentile, 18% with BMI 85–94.9th percentile, and 25% with BMI ≥ 95th percentile.

Participants in each (unrelated) sample were obtained via Qualtrics Panel Services, which utilizes a variety of sources (e.g., social media ads, targeted email lists) for recruitment. Survey invitations were emailed and included a hyperlink to proceed to the online questionnaire, along with the expected duration of the survey and a description of available participation incentives; informed written consent was required prior to beginning the survey, and for those under the age of 13 was obtained from their parents. As part of the consent process, parent sample participants read that the study aimed to learn about the ways that parents typically talk about weight with their children, and adolescent sample participants read that the study aimed to learn about how parents and teens talk about body weight. After completing the survey, participants were compensated with incentives managed by Qualtrics (e.g., gift cards, vouchers, cash, and redeemable points). Data collection occurred between October and December 2021, and study procedures were approved by the University of Connecticut Institutional Review Board. Additional details describing data collection and sample composition are reported elsewhere.[23]

2.2 | Measures

2.2.1 | Demographic and weight-related characteristics

Parents reported their sex, age, and race/ethnicity. For responding to questions about their child, parents were asked to provide their child's sex, gender identity, date of birth, current weight and height, and whether their child tried to lose weight or keep from gaining weight in the past year[24] (i.e., During the past year, have you or your child done anything to help him/her to try to lose weight or keep from gaining weight?). In the unrelated adolescent sample, participants reported their race/ethnicity, sex assigned at birth, year and month they were born, height, and weight. Sex, age, height, and weight were used to calculate the BMI percentile based on the Centers for Disease Control and Prevention (CDC) 2000 growth charts.[25] Adolescents were asked whether they have tried to lose weight or keep from gaining weight in the past year.

2.2.2 | Reasons for engaging in, or avoiding, weight talk

Parental motivations. Two self-report scales were used to assess parental motivations for engaging in or avoiding conversations with their child about his/her weight, developed and tested in recent research.[26] The first scale measures parental motivations for engaging in weight talk with their child (*Reasons for Weight Talk*), which includes reasons such as concerns about their child's health and wanting their child to feel that he/she can talk to them about weight; prior to this scale, participants were asked to indicate if they never talk with their child about his/her weight, and those who responded affirmatively were not presented with the *Reasons for Weight Talk* scale. The original scale included 8 items; two additional items (items 9 and 10) were added for the present study as additional positive intentions of engaging in weight talk, including wanting their child to feel good about his/her body weight and to accept his/her body size (see Table 1). The second scale (*Reasons for Avoiding Weight Talk*) assesses motivations for avoiding weight communication, such as not wanting to damage their child's self-esteem or not feeling comfortable talking to their child about weight; prior to this scale, participants were asked to indicate if they do not avoid talking with their child about his/her body weight, and those who responded affirmatively were not presented with the *Reasons for Avoiding Weight Talk* scale. The original scale has 7 items; three additional items (items 8–10) were added to assess avoiding weight talk so that their child does not feel pressured to be a certain weight or size, wanting their child to focus on being healthy rather than weight, and wanting their child to accept his/her body size (see Table 3). Items in both scales use 7-point Likert ratings, ranging from 1 = *strongly disagree* to 7 = *strongly agree*. Item development for both scales was informed by prior qualitative research examining motivations for weight talk among racially and economically diverse samples of parents,[8,18–22,27–30] and the original scales were tested in a racially/ethnically and economically diverse sample of mothers and fathers.[26] In the present study, Cronbach's alpha was 0.80 for the *Reasons for Weight Talk* scale and 0.84 for the *Reasons for Avoiding Weight Talk* scale.

Adolescent motivations. To assess adolescent motivations for engaging in or avoiding weight conversations with their parents, two scales were developed for this study with items similar to the parental motivation scales described above. For adolescent motivations to talk about their weight with their parents, 11 items were used; these items were presented only to participants who did not respond affirmatively to an initial question asking if they never talk with their parent(s) about their body weight. Several items directly mirrored items from the parent scale, such as adolescents having concerns about their health, a doctor telling them to do something about their weight, or wanting their parents to help them lose weight so that they will not be teased or bullied by others. Other items reflect positive reasons (e.g., feeling good about their weight and how their body looks), negative reasons (e.g., not feeling good about their weight or being worried about their weight), or wanting their parents to understand their feelings (e.g., wanting their parents to know what it feels like to struggle with weight, to understand that they are being treated badly because of their weight, or not to take their weight so seriously). For adolescent motivations to avoid talking about weight with their parents,

12 items were used; these items were presented only to participants who did not indicate that they never avoid talking with their parent(s) about their body weight. Several of these items mirrored items from the parent scale, such as avoiding weight talk because they do not want to obsess about weight, their weight is not an issue, they do not consider body weight to be a big deal, or their family considers it rude or unkind to talk about someone's weight. Other items reflect positive reasons (e.g., liking how they look and feel good about their weight) and negative reasons (e.g., feeling embarrassed, upset, or uncomfortable talking about their weight with their parents). Items in both scales use 7-point Likert ratings, ranging from 1 = *strongly disagree* to 7 = *strongly agree*. Cronbach's alpha was 0.80 for the Adolescent *Reasons for Weight Talk* scale and 0.70 for the Adolescent *Reasons for Avoiding Weight Talk* scale.

2.2.3 | Weight bias internalization

Both the parent and unrelated adolescent sample completed the 10-item Modified Weight Bias Internalization Scale (WBIS-M),[31–33] which measures self-directed blame and negative self-judgement due to body weight and internalization of negative weight-based stereotypes. Sample items include "My weight is a major way that I judge my value as a person" and "I hate myself for my weight". Items are rated on a 7-point scale (1 = *strongly disagree* to 7 = *strongly agree*) and were averaged, with higher values indicating greater levels of internalization. Cronbach's alpha was 0.94 in the parent sample and 0.95 in the adolescent sample.

2.3 | Analytic plan

Data were analysed in SPSS, version 28. Descriptive information regarding motivations for talking about weight is provided for the parent and unrelated adolescent samples. Sociodemographic and child weight-related differences, tested via a series of one-way analyses of variance (ANOVA), proceed with results pertaining to each sample. Sociodemographic comparisons include investigation of sex (i.e., male/female; excluding five individuals in the parent sample who indicated another sex) and racial/ethnic (i.e., Black or African American, White, Latinx; excluding those who indicated another race/ethnicity due to low prevalence). Weight-related comparisons include investigation of differences based on child weight status (BMI percentile categories), and weight management status (i.e., differentiating youth who have, versus have not engaged in weight management in the past year). Subsequently, motivations for avoiding conversations about weight are described for the overall samples, followed by comparisons based on sociodemographic and child weight-related characteristics (as described above). Finally, bivariate correlations are reported between weight bias internalization (WBI) and each of the motivations for and against weight talk. Missing data were handled using listwise deletion and $p < 0.01$ was used to define statistical significance due to the multitude of comparisons.

3 | RESULTS

3.1 | Parent motivations for talking about weight with their child

Overall, 65% of parents (72% of fathers, 60% of mothers) indicated they talk with their child about his/her body weight. Table 1 reports parents' motivations for engaging in weight communication. The strongest motivations endorsed by parents for talking about weight included wanting their child to feel good about his/her weight, and wanting their child to feel that he/she can talk with them about their weight. The weakest motivations pertained to engaging in weight communication because the parent was told by a doctor or other professional to do something about their child's weight, or as a way for parents to show their child affection.

Several differences emerged in parental motivations for talking about weight across sociodemographic and weight-related characteristics (see Table 1). For example, showing affection to their child and wanting to help their child lose weight so they will not get teased were significantly stronger motivations for fathers talking about weight with their children than for mothers. Mothers reported stronger motivation than fathers to talk about weight because they want their child to feel good about his/her body weight and accept his/her body size. Both mothers and fathers reported high agreement that they engage in weight communication because they want their child to feel that he/she can talk to them about weight.

Weight talk motivations also differed based on race/ethnicity; for example, wanting one's child to feel good about his/her body weight was a stronger motivation for weight talk among Black/African American parents relative to White parents. Talking about weight with children to show affection, to discourage them from taking their weight so seriously, or in response to comments from a health professional were stronger motivations for Latinx parents compared to Black/African American parents.

Compared to parents of children with lower BMI categories, parents of youth with BMI ≥ 95th percentile reported stronger motivation to engage in weight talk for the following reasons: a health professional had told them to address their child's weight; to help their child lose weight so they will not get teased; and because they know what it feels like to struggle with weight and want their child to know they understand their experiences. This same pattern of findings occurred for parents whose child was engaged in weight management compared to those who were not trying to manage their weight. Regardless of their child's weight status or whether their child was engaged in weight management, all parents were similarly motivated to engage in weight talk as a way to promote their child's body size acceptance.

3.2 | Adolescent motivations for talking about weight with parent(s)

In the unrelated adolescent sample, 47% of adolescents (48% boys, 46% girls) indicated that they talk about their weight with their

TABLE 1 Parent-reported motivations for talking about weight with their children

	Overall	Sex differences		Race/ethnicity differences			Child weight status differences				Child weight management differences	
I talk with my child about his/her body weight because…	*M* (SD)	Fathers *M* (SD)	Mothers M (SD)	White *M* (SD)	Black or African American *M* (SD)	Latinx *M* (SD)	BMI <5th percentile *M* (SD)	BMI 5–84.9th percentile *M* (SD)	BMI 85–94.9th percentile *M* (SD)	BMI ≥95th percentile *M* (SD)	No *M* (SD)	Yes *M* (SD)
1. I want my child to feel good about his/her body weight	5.77 (1.28)	5.56[a] (1.31)	5.99[b] (1.21)	5.61[a] (1.27)	5.90[b] (1.35)	5.80[a,b] (1.19)	5.78[a] (1.35)	5.83[a] (1.24)	5.71[a] (1.29)	5.69[a] (1.30)	5.81[a] (1.38)	5.75[a] (1.22)
2. I want my child to feel that he/she can talk to me about his/her weight	5.75 (1.26)	5.68[a] (1.21)	5.82[a] (1.30)	5.64[a] (1.21)	5.87[a] (1.33)	5.74[a] (1.23)	5.62[a] (1.47)	5.72[a] (1.29)	5.70[a] (1.20)	5.88[a] (1.14)	5.53[a] (1.49)	5.85[b] (1.11)
3. I want my child to accept his/her body size	5.36 (1.43)	5.23[a] (1.42)	5.50[b] (1.43)	5.25[a] (1.44)	5.35[a,b] (1.58)	5.50[b] (1.23)	5.47[a] (1.48)	5.38[a] (1.46)	5.30[a] (1.40)	5.32[a] (1.36)	5.41[a] (1.54)	5.35[a] (1.36)
4. I'm concerned about his/her health	5.14 (1.69)	5.21[a] (1.61)	5.07[a] (1.76)	5.31[a] (1.50)	4.93[b] (1.90)	5.21[ab] (1.59)	5.26[a,b] (1.64)	4.87[a] (1.86)	5.19[a] (1.48)	5.59[b] (1.34)	4.59[a] (1.84)	5.42[b] (1.53)
5. I know what it feels like to struggle with body weight, and I want my child to know that I understand what they are experiencing	4.91 (1.80)	4.92[a] (1.71)	4.90[a] (1.89)	4.94[a,b] (1.73)	4.73[a] (2.02)	5.11[b] (1.58)	4.63[a,b] (1.84)	4.63[a] (1.90)	5.04[b] (1.68)	5.49[c] (1.43)	4.14[a] (1.99)	5.28[b] (1.57)
6. I want to get him/her to not take weight so seriously	4.67 (1.70)	4.83[a] (1.63)	4.50[b] (1.77)	4.75[a] (1.66)	4.31[b] (1.83)	4.96[a] (1.54)	4.75[a] (1.73)	4.62[a] (1.74)	4.52[a] (1.61)	4.83[a] (1.67)	4.30[a] (1.76)	4.85[b] (1.64)
7. I want to help him/her develop a thick skin so that they will not be upset if others tease or bully them because of their weight	4.33 (1.94)	4.58[a] (1.80)	4.06[b] (2.05)	4.24[a] (1.89)	4.21[a] (2.06)	4.56[a] (1.86)	4.53[a,c] (1.99)	4.00[b] (1.98)	4.21[a,b] (1.85)	4.96[c] (1.76)	3.75[a] (2.00)	4.62[b] (1.85)
8. I want to help him/her lose weight so that they will not get teased or bullied by others for their weight	4.21 (2.02)	4.60[a] (1.90)	3.77[b] (2.06)	4.29[a] (1.89)	3.75[b] (2.10)	4.56[a] (1.98)	4.17[a,b] (2.11)	3.70[a] (2.02)	4.31[b] (1.88)	5.11[c] (1.68)	3.16[a] (1.96)	4.72[b] (1.84)
9. That's one way I show my child affection	4.15 (1.99)	4.53[a] (1.83)	3.72[b] (2.07)	4.19[a,b] (1.95)	3.85[a] (2.06)	4.44[b] (1.90)	4.45[a] (2.07)	3.92[b] (2.01)	3.84[b] (2.07)	4.63[a] (1.77)	3.48[a] (1.95)	4.47[b] (1.93)
10. A doctor or other professional told me to do something about my child's weight	4.13 (2.04)	4.51[a] (1.92)	3.72[b] (2.08)	4.30[a] (2.00)	3.67[b] (2.09)	4.44[a] (1.94)	3.98[a,b] (2.06)	3.61[a] (2.01)	4.21[b] (1.96)	5.13[c] (1.75)	3.07[a] (1.98)	4.66[b] (1.85)

Note: Item response values range from 1 (*strongly disagree*) – 7 (*strongly agree*). Values within the same row and subgrouping not sharing the same letter (e.g., a, b vs. c) are significantly different from each other at $p < 0.01$. Descriptives calculated only among parents who did not indicate "never" talking with their child about his/her body weight.

TABLE 2 Adolescent-reported motivations for talking about weight with their parent(s)

I talk with my parent(s) about my body weight because…	Overall	Sex differences		Race/ethnicity differences			Weight status differences				Weight management differences	
	M (SD)	Boys *M* (SD)	Girls *M* (SD)	White *M* (SD)	Black or African American *M* (SD)	Latinx *M* (SD)	BMI <5th percentile *M* (SD)	BMI 5–84.9th percentile *M* (SD)	BMI 85–94.9th percentile *M* (SD)	BMI ≥95th percentile *M* (SD)	No *M* (SD)	Yes *M* (SD)
1. I'm concerned about my health	4.28 (1.86)	4.44^{a} (1.86)	4.17^{a} (1.86)	4.32^{a} (1.89)	4.26^{a} (1.89)	4.34^{a} (1.78)	4.42^{a,b} (2.04)	3.99^{a} (1.95)	4.33^{a,b} (1.81)	4.79^{b} (1.55)	3.68^{a} (1.85)	4.68^{b} (1.77)
2. I'm worried about my weight	4.19 (1.88)	4.18^{a} (1.88)	4.19^{a} (1.87)	4.21^{a} (1.92)	3.99^{a} (1.84)	4.44^{a} (1.79)	4.24^{a,b,c} (2.07)	3.75^{a} (1.94)	4.39^{b} (1.66)	4.90^{c} (1.60)	3.33^{a} (1.90)	4.75^{b} (1.63)
3. I do not feel good about my weight	4.15 (2.00)	4.04^{a} (2.02)	4.23^{a} (1.98)	4.16^{a,b} (1.99)	3.89^{a} (2.06)	4.39^{b} (1.94)	4.00^{a,b} (2.00)	3.70^{a} (2.02)	4.45^{b,c} (1.84)	4.86^{c} (1.83)	3.23^{a} (1.94)	4.76^{b} (1.79)
4. I feel good about my weight	4.06 (1.89)	4.34^{a} (1.77)	3.87^{b} (1.95)	4.14^{a} (1.84)	4.30^{a} (1.97)	3.97^{a} (1.85)	4.18^{a} (1.89)	4.47^{a} (1.81)	4.12^{a} (1.90)	3.21^{b} (1.79)	4.57^{a} (1.81)	3.72^{b} (1.88)
5. I like the way my body looks	4.04 (1.85)	4.28^{a} (1.78)	3.87^{b} (1.89)	4.05^{a} (1.81)	4.33^{a} (1.93)	3.91^{a} (1.81)	4.50^{a} (1.78)	4.35^{a} (1.76)	4.22^{a} (1.73)	3.21^{b} (1.89)	4.50^{a} (1.73)	3.73^{b} (1.87)
6. I want them to not take my weight so seriously	3.55 (1.88)	3.60^{a} (1.85)	3.52^{a} (1.91)	3.58^{a} (1.92)	3.35^{a} (1.84)	3.80^{a} (1.79)	3.94^{a,b} (1.97)	3.38^{a} (1.89)	3.55^{a,b} (1.96)	3.81^{b} (1.75)	3.16^{a} (1.81)	3.81^{b} (1.88)
7. They focus on my weight	3.51 (2.02)	3.64^{a} (1.96)	3.42^{a} (2.05)	3.53^{a} (1.99)	3.41^{a} (2.02)	3.68^{a} (2.00)	3.52^{a,b} (2.09)	3.18^{a} (1.98)	3.72^{b} (2.03)	4.02^{b,c} (1.94)	2.88^{a} (1.88)	3.94^{b} (2.00)
8. A doctor told me to do something about my weight	3.49 (2.15)	3.82^{a} (2.12)	3.26^{b} (2.14)	3.48^{a} (2.18)	3.53^{a} (2.09)	3.73^{a} (2.15)	3.24^{a,b} (2.16)	2.96^{a} (2.06)	3.61^{b} (2.09)	4.52^{c} (1.99)	2.89^{a} (2.04)	3.89^{b} (2.13)
9. I want them to help me lose weight so that I will not get teased or bullied by others	3.40 (2.16)	3.64^{a} (2.15)	3.22^{b} (2.15)	3.50^{a} (2.20)	3.44^{a} (2.17)	3.58^{a} (2.13)	3.18^{a,b} (2.32)	2.87^{a} (2.05)	3.65^{b} (2.14)	4.31^{c} (2.04)	2.62^{a} (1.93)	3.92^{b} (2.15)
10. I want them to know what it feels like to struggle with body weight	3.31 (2.07)	3.37^{a} (2.08)	3.27^{a} (2.07)	3.33^{a} (2.09)	3.35^{a} (2.03)	3.56^{a} (2.07)	3.80^{a} (2.17)	2.93^{b} (2.02)	3.65^{a} (2.06)	3.71^{a} (2.02)	2.74^{a} (1.91)	3.68^{b} (2.08)
11. I want them to understand that I am being treated badly because of my weight	2.97 (2.03)	3.22^{a} (2.07)	2.79^{b} (1.98)	3.13^{a} (2.08)	2.95^{a} (2.02)	3.11^{a} (2.05)	3.34^{a,b} (2.15)	2.61^{a} (1.94)	3.16^{b} (2.12)	3.47^{b,c} (1.97)	2.51^{a} (1.84)	3.28^{b} (2.09)

Note: Item response values range from 1 (*strongly disagree*) – 7 (*strongly agree*). Values within the same row and subgrouping not sharing the same letter (e.g., a, b vs. c) are significantly different from each other at $p < 0.01$. Descriptives calculated only among adolescents who did not indicate 'never' talking with their parent(s) about their body weight.

TABLE 3 Parent-reported motivations for avoiding talking about weight with their children

		Sex differences		Race/ethnicity differences			Child weight status differences				Child weight management differences	
I avoid talking with my child about his/her body weight because…	Overall *M* (SD)	Fathers *M* (SD)	Mothers *M* (SD)	White *M* (SD)	Black or African American *M* (SD)	Latinx *M* (SD)	BMI <5th percentile *M* (SD)	BMI 5–84.9th percentile *M* (SD)	BMI 85–94.9th percentile *M* (SD)	BMI ≥95th percentile *M* (SD)	No *M* (SD)	Yes *M* (SD)
1. I want my child to accept his/her body size	5.59 (1.32)	5.46^{a} (1.23)	5.73^{b} (1.42)	5.52^{a} (1.24)	5.47^{a} (1.53)	5.69^{a} (1.24)	5.59^{a} (1.42)	5.61^{a} (1.35)	5.60^{a} (1.30)	5.51^{a} (1.23)	5.76^{a} (1.32)	5.48^{b} (1.31)
2. I want my child to focus on being healthy, not on how much he/she weighs	5.55 (1.39)	5.44^{a} (1.28)	5.69^{b} (1.51)	5.49^{a} (1.29)	5.49^{a} (1.62)	5.60^{a} (1.31)	5.63^{a} (1.54)	5.56^{a} (1.39)	5.72^{a} (1.39)	5.43^{a} (1.32)	5.76^{a} (1.43)	5.43^{b} (1.36)
3. I do not want my child to feel pressured to be a certain body weight or size	5.34 (1.56)	5.23^{a} (1.47)	5.49^{a} (1.66)	5.23^{a} (1.51)	5.17^{a} (1.73)	5.50^{a} (1.45)	5.17^{a} (1.72)	5.28^{a} (1.60)	5.44^{a} (1.48)	5.41^{a} (1.46)	5.38^{a} (1.63)	5.32^{a} (1.52)
4. I do not want my child to obsess over body weight	5.34 (1.59)	5.19^{a} (1.54)	5.53^{b} (1.63)	5.23^{a} (1.48)	5.11^{a} (1.90)	5.55^{b} (1.44)	5.23^{a} (1.82)	5.33^{a} (1.62)	5.34^{a} (1.56)	5.37^{a} (1.45)	5.41^{a} (1.74)	5.29^{a} (1.50)
5. I do not want to damage my child's self-esteem	5.20 (1.66)	5.06^{a} (1.64)	5.37^{b} (1.66)	5.15^{a} (1.54)	5.05^{a} (1.90)	5.31^{a} (1.57)	4.99^{a} (1.89)	5.17^{a} (1.69)	5.24^{a} (1.68)	5.32^{a} (1.47)	5.11^{a} (1.84)	5.24^{a} (1.55)
6. In my family, we consider it rude or unkind to talk about someone's body weight	4.92 (1.68)	5.01^{a} (1.53)	4.80^{a} (1.84)	4.93^{a} (1.59)	4.45^{b} (1.87)	5.19^{a} (1.58)	5.13^{a,b} (1.69)	4.69^{a} (1.71)	5.01^{a,b} (1.72)	5.13^{b} (1.56)	4.62^{a} (1.82)	5.07^{b} (1.58)
7. My child's weight is not an issue	4.91 (1.81)	4.89^{a} (1.70)	4.93^{a} (1.93)	4.75^{a} (1.76)	4.79^{a,b} (2.02)	5.12^{b} (1.65)	5.27^{a} (1.85)	5.02^{a} (1.81)	4.80^{a,b} (1.76)	4.64^{b} (1.77)	5.39^{a} (1.74)	4.63^{b} (1.79)
8. Others have made me feel bad about my weight, so I do not want my child to go through the same experience	4.75 (1.84)	4.74^{a} (1.77)	4.76^{a} (1.93)	4.81^{a} (1.69)	4.06^{b} (2.09)	5.14^{c} (1.63)	4.52^{a} (2.09)	4.60^{a} (1.87)	4.68^{a,b} (1.86)	5.13^{b} (1.62)	4.03^{a} (2.06)	5.15^{b} (1.57)
9. In my family, we do not consider body weight to be a big deal	4.47 (1.77)	4.70^{a} (1.65)	4.16^{b} (1.86)	4.43^{a} (1.71)	3.98^{b} (1.90)	4.83^{c} (1.67)	4.46^{a} (1.79)	4.36^{a} (1.82)	4.40^{a} (1.73)	4.67^{a} (1.69)	4.34^{a} (1.82)	4.53^{a} (1.74)
10. I do not know what it feels like to struggle with body weight, so I do not feel comfortable talking to my child about their weight	4.17 (2.02)	4.54^{a} (1.81)	3.69^{b} (2.17)	4.23^{a} (1.89)	3.61^{b} (2.12)	4.50^{a} (1.99)	4.20^{a,b} (2.17)	3.99^{a} (1.99)	3.78^{a} (2.13)	4.69^{b} (1.85)	3.66^{a} (2.07)	4.46^{b} (1.93)

Note: Item response values range from 1 (*strongly disagree*) – 7 (*strongly agree*). Values within the same row and subgrouping not sharing the same letter (e.g., a, b vs. c) are significantly different from each other at $p < 0.01$.

parents. Table 2 presents adolescents' motivation for this communication. Generally, adolescents reported being most strongly motivated to talk with their parent(s) about their weight because of health concerns, being worried about their weight, or not feeling good about their weight. Differences in adolescents' motivations for talking about weight with parents were most robust as a function of weight-related characteristics. Notably, talking about weight because of being dissatisfied with their body weight, because a doctor had told them to address their weight, and because they want their parents to help them lose weight to reduce getting teased were reported as significantly stronger motivations for adolescents with the highest BMI and those engaged weight management (compared to adolescents not managing their weight and in lower BMI categories). Adolescents with BMI <95th percentile reported stronger motivation for engaging in weight conversations because they feel good about their weight compared to adolescents with higher BMI. Few racial/ethnic differences in adolescent motivations emerged, only that talking to parents about their weight because they do not feel good about their weight was a significantly stronger motivation for Latinx, as compared to Black/African American, adolescents. Finally, sex differences emerged in which boys endorsed stronger motivations than girls for talking to their parents about weight because of a doctor telling them to do something about their weight, wanting help to lose weight and wanting parents to understand that they are being treated badly because of their weight, and feeling good about their weight and appearance.

3.3 | Parent motivations for avoidance of talking about weight with their child

Overall, 35% of parents (28% of fathers, 40% of mothers) indicated that they never talk with their child about his/her body weight. Table 3 reports parents' motivations for the avoidance of such communication. Overall, parents reported being most motivated to avoid talking about weight with their child because they want their child to accept his/her body size, to focus on being healthy (not how much he/she weighs), and not to feel pressured to be a certain body size or obsess about weight, and to avoid damaging their child's self-esteem.

Sociodemographic differences in avoiding weight talk were revealed, along with differences based on child weight-related characteristics. For example, compared to fathers, mothers reported stronger motivation to avoid weight conversations with their children because they do not want to damage their child's self-esteem or their child to obsess about weight, and they want their child to accept his/her body size and focus on being healthy. Compared to White and Black/African American parents, Latinx parents reported stronger motivations to avoid weight talk because they do not want their child to obsess about weight; because they do not consider body weight to be a big deal in their family; or because they had been made to feel bad about their own weight by others and do not want their child to have the same experience.

Relative to parents of children not engaged in weight management, parents of children actively managing their weight reported significantly stronger motivations to avoid weight talk because others have made them feel bad about their own weight and they do not want their child to have the same experience, or conversely because they do not know what it feels like to struggle with body weight and therefore do not feel comfortable talking to their child about their weight. Most parents, regardless of their child's weight status or engagement in weight management, were similarly motivated to avoid weight conversations because they do not want to damage their child's self-esteem or feel pressured to be a certain weight or size or obsess about body weight.

3.4 | Adolescent motivations for avoidance of talking about weight with their parent(s)

Overall, 53% of adolescents (52% of boys, 54% of girls) indicated that they never talk with their parent(s) about their body weight. Table 4 presents adolescents' motivations for avoiding this communication. Adolescents reported being most strongly motivated to avoid talking with their parent(s) about their weight because they do not want to obsess about their weight or for their parent(s) to obsess about it, or because talking about their weight makes them feel embarrassed or upset about their weight.

Sex differences were prevalent among two-thirds of the avoidance motivation items; for example, boys, compared to girls, endorsed a greater agreement with avoiding weight talk with parent(s) due to feeling good about their weight and liking how they look, while girls reported stronger motivations to avoid weight talk because they do not feel comfortable and it makes them embarrassed. Relative to their White and Black/African American counterparts, Latinx adolescents reported greater agreement with avoiding weight conversations with their parent(s) because it makes them feel upset or embarrassed to talk about their weight. Adolescents with BMI < 95th percentile, as well as those not engaged in weight management, reported positive affect about their weight and bodies as stronger motivations for avoiding weight talk with their parents compared to adolescents with BMI ≥ 95th percentile and those engaged in weight management. Adolescents engaged (versus not engaged) in weight management, endorsed a greater agreement with avoiding weight conversations because it makes them feel embarrassed and they do not feel comfortable talking about it.

3.5 | Associations with weight bias internalization

Parents who indicated engaging in weight communication with their child reported higher levels of WBI ($M = 3.72$, SD = 1.63) compared to those who did not ($M = 3.02$, SD = 1.62), $t(1934) = 8.94$, $p < 0.001$; however, adolescents who engaged in weight communication with their parents had similar levels of WBI ($M = 3.47$, SD = 1.72) to those who did not ($M = 3.48$, SD = 1.70) [WBI, $t(2018) = -0.08$, $p = 0.936$]. Additionally, parents with a child engaged in weight management reported higher levels of WBI ($M = 3.97$,

TABLE 4 Adolescent-reported motivations for avoiding talking about weight with their parent(s)

I avoid talking with my parent(s) about my body weight because…	Overall	Sex differences		Race/ethnicity differences			Weight status differences				Weight management differences	
	M (SD)	Boys *M* (SD)	Girls *M* (SD)	White *M* (SD)	Black or African American *M* (SD)	Latinx *M* (SD)	BMI <5th percentile *M* (SD)	BMI 5–84.9th percentile *M* (SD)	BMI 85–94.9th percentile *M* (SD)	BMI ≥95th percentile *M* (SD)	No *M* (SD)	Yes *M* (SD)
1. I do not want to obsess about my weight	4.99 (1.61)	4.92^{a} (1.60)	5.04^{a} (1.62)	5.01^{a} (1.57)	4.92^{a} (1.71)	5.05^{a} (1.57)	5.16^{a} (1.69)	5.02^{a} (1.67)	4.94^{a} (1.54)	4.95^{a} (1.53)	4.94^{a} (1.68)	5.03^{a} (1.57)
2. I do not want my parent(s) to obsess over my weight	4.75 (1.80)	4.66^{a} (1.71)	4.80^{a} (1.86)	4.71^{a,b} (1.81)	4.51^{a} (1.89)	4.89^{b} (1.69)	5.02^{a} (1.87)	4.67^{a} (1.81)	4.63^{a} (1.79)	4.91^{a} (1.77)	4.52^{a} (1.86)	4.91^{b} (1.75)
3. It makes me feel embarrassed about my weight	4.60 (1.89)	4.39^{a} (1.79)	4.74^{b} (1.93)	4.52^{a} (1.89)	4.26^{a} (1.89)	4.97^{b} (1.77)	4.60^{a,b} (2.14)	4.35^{a} (1.93)	4.67^{a,b} (1.80)	5.01^{b} (1.75)	4.13^{a} (1.93)	4.92^{b} (1.79)
4. It makes me upset to talk about my weight	4.58 (1.87)	4.40^{a} (1.81)	4.69^{b} (1.89)	4.56^{a} (1.87)	4.20^{b} (1.92)	4.94^{c} (1.78)	4.72^{a,b} (1.89)	4.37^{a} (1.88)	4.47^{a} (1.88)	5.00^{b} (1.78)	4.06^{a} (1.88)	4.92^{b} (1.78)
5. I do not feel comfortable talking about my weight with them	4.49 (1.88)	4.21^{a} (1.84)	4.67^{b} (1.89)	4.40^{a,b} (1.88)	4.24^{a} (1.82)	4.73^{b} (1.86)	4.60^{a,b} (1.87)	4.40^{a} (1.93)	4.23^{a} (1.85)	4.81^{b} (1.78)	4.14^{a} (1.86)	4.73^{b} (1.86)
6. My weight is not an issue	4.21 (1.89)	4.40^{a} (1.81)	4.09^{b} (1.93)	4.21^{a} (1.89)	4.39^{a} (1.86)	4.16^{a} (1.83)	4.41^{a,b} (1.86)	4.59^{a} (1.83)	4.19^{b} (1.77)	3.53^{c} (1.87)	4.72^{a} (1.85)	3.88^{b} (1.84)
7. Others have made me feel bad about my weight, so I do not want my parent(s) to do the same	4.15 (1.99)	4.01^{a} (1.89)	4.24^{a} (2.05)	4.20^{a,b} (2.02)	3.87^{a} (1.98)	4.46^{b} (1.89)	4.28^{a,b} (2.07)	3.92^{a} (2.03)	4.10^{a} (1.86)	4.57^{b} (1.94)	3.65^{a} (1.99)	4.48^{b} (1.94)
8. In my family, we consider it rude or unkind to talk about someone's body weight	4.14 (1.78)	4.40^{a} (1.70)	3.98^{b} (1.82)	4.34^{a} (1.74)	3.98^{b} (1.83)	4.27^{a,b} (1.73)	4.55^{a} (1.62)	4.22^{a} (1.78)	4.10^{a} (1.69)	3.97^{a} (1.86)	4.34^{a} (1.70)	4.02^{b} (1.83)
9. I do not want to upset my parent(s)	4.02 (1.88)	4.14^{a} (1.80)	3.94^{a} (1.93)	4.15^{a} (1.86)	3.79^{b} (1.92)	4.25^{a} (1.84)	4.45^{a} (2.03)	3.92^{a} (1.87)	4.09^{a} (1.89)	4.07^{a} (1.86)	3.72^{a} (1.84)	4.21^{b} (1.89)
10. In my family, we do not consider body weight to be a big deal	4.01 (1.80)	4.31^{a} (1.76)	3.81^{b} (1.79)	4.20^{a} (1.75)	3.83^{b} (1.78)	4.06^{a,b} (1.83)	4.17^{a} (1.83)	4.10^{a} (1.76)	3.98^{a} (1.79)	3.83^{a} (1.86)	4.19^{a} (1.72)	3.88^{b} (1.84)
11. I feel good about my weight	4.01 (1.93)	4.35^{a} (1.84)	3.79^{b} (1.95)	4.05^{a} (1.86)	4.20^{a} (1.95)	4.00^{a} (1.94)	4.40^{a} (1.73)	4.34^{a} (1.88)	4.03^{a} (1.79)	3.35^{b} (1.96)	4.53^{a} (1.82)	3.68^{b} (1.91)
12. I like how I look	3.97 (1.91)	4.30^{a} (1.78)	3.76^{b} (1.96)	4.02^{a,b} (1.90)	4.27^{a} (1.94)	3.87^{b} (1.84)	4.57^{a} (1.79)	4.20^{a} (1.89)	4.15^{a} (1.83)	3.35^{b} (1.87)	4.45^{a} (1.85)	3.65^{b} (1.88)

Note: Item response values range from 1 (*strongly disagree*) – 7 (*strongly agree*). Values within the same row and subgrouping not sharing the same letter (e.g., a, b vs. c) are significantly different from each other at $p < 0.01$.

TABLE 5 Bivariate correlations between weight bias internalization (WBI) and motivations for weight communication

Parent-reported motivations	
I talk with my child about his/her body weight because…	*WBI r*
1. I'm concerned about his/her health	0.20*
2. A doctor or other professional told me to do something about my child's weight	0.37*
3. I want to help him/her develop a thick skin so that they will not be upset if others tease or bully them because of their weight	0.27*
4. I want to help him/her lose weight so that they will not get teased or bullied by others for their weight	0.38*
5. I know what it feels like to struggle with body weight, and I want my child to know that I understand what they are experiencing	0.34*
6. That's one way I show my child affection	0.27*
7. I want my child to feel that he/she can talk to me about his/her weight	0.04
8. I want to get him/her to not take weight so seriously	0.22*
9. I want my child to accept his/her body size	0.09*
10. I want my child to feel good about his/her body weight	0.01
Adolescent-reported motivations	
I talk with my parent(s) about my body weight because…	*WBI r*
1. I'm concerned about my health	0.29*
2. I feel good about my weight	−0.46*
3. I like the way my body looks	−0.45*
4. I'm worried about my weight	0.56*
5. I do not feel good about my weight	0.65*
6. They focus on my weight	0.44*
7. A doctor told me to do something about my weight	0.39*
8. I want them to help me lose weight so that I will not get teased or bullied by others	0.49*
9. I want them to not take my weight so seriously	0.34*
10. I want them to understand that I am being treated badly because of my weight	0.45*
11. I want them to know what it feels like to struggle with body weight	0.49*

*$p < 0.001$.

SD = 1.58) than those whose child was not engaged in weight management ($M = 2.94$, SD = 1.57), $t(1924) = -14.29$, $p < 0.001$. Finally, higher levels of WBI were present in parents who had a child with BMI > 95th percentile ($M = 4.14$, SD = 1.59) compared to those with a child at a lower BMI ($M = 3.28$, SD = 1.63), $t(1887) = -9.54$, $p < 0.001$.

Bivariate correlations between parent- and adolescent-reported motivations for weight communication and WBI are presented in Table 5. Among parents, higher levels of WBI were most strongly correlated with motivations to talk with their children about weight because they want to help them lose weight to avoid being teased ($r = 0.38$), because a health professional told them to do something about their child's weight ($r = 0.37$), or because they know what it feels like to struggle with weight and want their child to know they understand their experiences ($r = 0.34$). Among adolescents, motivations for weight communication due to feeling worried or 'not feeling good' about their weight were most strongly related to higher levels of WBI. In contrast, talking about weight with parents because they feel positive about their bodies was negatively associated with WBI.

TABLE 6 Bivariate correlations between weight bias internalization (WBI) and motivations for avoiding weight communication

Parent-reported motivations	
I avoid talking with my child about his/her body weight because…	*WBI r*
1. My child's weight is not an issue	0.08
2. I do not want to damage my child's self-esteem	0.18**
3. I do not want my child to obsess over body weight	0.12**
4. I do not know what it feels like to struggle with body weight, so I do not feel comfortable talking to my child about their weight	0.25**
5. Others have made me feel bad about my weight, so I do not want my child to go through the same experience	0.46**
6. In my family, we do not consider body weight to be a big deal	0.26**
7. In my family, we consider it rude or unkind to talk about someone's body weight	0.28**
8. I do not want my child to feel pressured to be a certain body weight or size	0.16**
9. I want my child to focus on being healthy, not on how much he/she weighs	0.06
10. I want my child to accept his/her body size	0.11**
Adolescent-reported motivations	
I avoid talking with my parent(s) about my body weight because…	*WBI r*
1. My weight is not an issue	−0.42**
2. I do not feel comfortable talking about my weight with them	0.40**
3. It makes me feel embarrassed about my weight	0.57**
4. I do not want to obsess about my weight	0.05
5. I feel good about my weight	−0.45**
6. I like how I look	−0.44**
7. I do not want to upset my parent(s)	0.26**
8. I do not want my parent(s) to obsess over my weight	0.23**
9. It makes me upset to talk about my weight	0.60**
10. Others have made me feel bad about my weight, so I do not want my parent(s) to do the same	0.55**
11. In my family, we do not consider body weight to be a big deal	−0.12**
12. In my family, we consider it rude or unkind to talk about someone's body weight	−0.07

**$p < 0.001$.

Table 6 displays bivariate correlations between WBI and parent- and adolescent-reported motivations for avoiding weight

communication. Among parents, WBI was most strongly related to avoidance of weight talk with children because parents themselves have been made to feel bad about their weight and do not want their child to go through the same experience ($r = 0.46$). Among adolescents, avoiding weight talk with parent(s) because it makes adolescents upset ($r = 0.60$) and embarrassed ($r = 0.57$) to talk about their weight was most strongly (positively) associated with WBI. In contrast, WBI was negatively associated with avoiding weight communication with parent(s) due to feeling good about one's weight ($r = -0.45$), liking how one looks ($r = -0.44$), and believing that one's weight is not an issue ($r = -0.42$).

4 | DISCUSSION

Our study provides novel insights and is the first quantitative investigation of adolescent motivations for engaging in or avoiding conversations about weight with parents. Our findings suggest that unrelated samples of parents and adolescents have a range of different reasons for talking about weight or avoiding the topic and that there are both similarities and differences in the extent of agreement with these reasons across sex, race/ethnicity, and weight status. These findings reiterate that perspectives about communicating about body weight within families are complex, multi-faceted, and may differ across sociodemographic characteristics.

Parents, irrespective of sex, race/ethnicity, and child's weight status, expressed stronger motivations for *engaging* in weight conversations with their child in order for their child to feel good about his/her weight, accept his/her body size, and wanting their child to feel that he/she can talk to them about weight compared to being motivated because a doctor or other health professional had raised their child's weight as a concern. These findings highlight the need for further investigation on positive parental weight communication. To date, the prevalence and nature of positive weight communication from parents have received little empirical attention.[23] Comments from parents about self-acceptance of weight, body size diversity, and/or body positivity could potentially benefit their child's wellbeing by challenging critical societal messages about the weight that youth are commonly exposed to. As our findings suggest that parents are motivated with these intentions in their weight communication to promote body esteem in their children, it will be important for future research to determine the impact of positive intentions and weight comments on adolescents' emotional and physical wellbeing.

Similarly, the most common parental motivations for *avoiding* conversations with their child about his/her weight were their desires for their child to accept his/her body size, to focus on being healthy (not how much he/she weighs), not to feel pressured to be a certain body size or obsess about weight, and to avoid damaging their child's self-esteem. Irrespective of their child's weight status or engagement in weight management, parents were similarly motivated to avoid weight conversations because they do not want their child to obsess about weight or feel pressured to be a certain weight or size, or damage their child's self-esteem.

These findings are informative for paediatric healthcare providers as they navigate weight-related health communication with families. Our findings suggest that parents may be aware of the potential harms of talking about weight for their child's emotional wellbeing and that this awareness contributes to their motivations to talk about weight in ways that promote body acceptance and protect their child's feelings, or as a reason to avoid talking about it altogether. Acknowledging these parental motivations can help paediatric providers approach weight-related topics with increased sensitivity and focus conversations on their child's health rather than a primary emphasis on weight. Integrating this awareness into motivational interviewing approaches used with parents and children could be beneficial, and help enhance the positive effects of motivational interviewing demonstrated on youth health outcomes and attrition.[34,35] Further, it may be beneficial for paediatric providers to talk to parents about ways that they can simultaneously promote their child's healthy lifestyle behaviours, body esteem, and self-acceptance. Scholars have begun to respond to this need with evidence-based resources to foster positive weight-related conversations with families in paediatric care.[36]

Beyond paediatric and primary care settings, future work should prioritize identifying effective strategies to support parents and adolescents in having healthier conversations about weight, particularly as opportunities for families to engage in weight-related conversations with primary care providers are not always possible and can be limited. It will be important to determine effective ways in which other clinicians, such as dietitians, primary health care nurses, and allied health professionals, can serve in supportive roles to families to promote positive communication about weight and health. Further, there may be relevant opportunities to educate and engage appropriate professionals in school settings, such as health educators, school nurses, and athletic coaches, to model respectful weight communication and support adolescents in weight-related conversations.

Parental concern about their child being teased about weight was most pronounced as a motivation for engaging in weight talk among parents of youth with the highest BMI and/or engaged in weight management (compared to those with lower weight or those not actively managing their weight). Some of these findings align with recent qualitative evidence of parents,[8] and reiterate the need to ensure that parents have strategies to address their concerns in ways that do not involve critical or negative communication about their child's weight. Further, parents with higher levels of WBI were more motivated to talk with their children about weight because they want to help them lose weight to avoid being teased, or because a health professional told them to do something about their child's weight. Overall, higher WBI was present in parents who engaged in weight communication, had a child with BMI > 95th percentile, or had a child engaged in weight management. These findings parallel recent evidence showing that parental WBI relates to higher frequency of child-centered weight conversations,[37] and suggests that parental self-devaluation about their own weight may contribute to communicating concerns to their child about his/her weight, particularly if the child has a higher weight.

Among adolescents, our findings suggest that approximately half avoid talking about their weight with parents, most often because it makes them feel embarrassed, upset, or because they do not want themselves or their parents to obsess about their weight. Reasons for avoiding these conversations differed for boys and girls; boys expressed stronger motivations for avoidance for positive reasons (e.g., feeling good about their weight and liking how they look) whereas girls reported stronger avoidance motivations for negative reasons (feeling uncomfortable and embarrassed). Similarly, Latinx adolescents, those in the highest BMI category, and those engaged in weight management expressed stronger motivations for avoiding weight conversations with parents because it makes them feel upset compared to White and Black/African American counterparts, adolescents with a BMI 5th < 95th percentile, and those not engaged in weight management. Given these findings, it will be important for future research to determine what aspects of weight conversations adolescents feel are most distressing, and whether there are positive forms of parental weight talk that make adolescents feel comfortable and supported. Of note, recent evidence has documented more frequent weight talk among Latinx parents than parents of other racial/ethnic groups[23]; given that Latinx adolescents reported stronger motivations to avoid weight conversations with parents, future studies should examine potential disconnect and conflicting perspectives in Latinx parent-adolescent weight communication.

When adolescents do talk about their weight with parents, boys in our study were more strongly motivated by wanting to lose weight or due to weight-related concerns from their doctor compared to girls. Latinx adolescents were more strongly motivated by weight-based dissatisfaction than Black/African American adolescents; this difference could be attributable, in part, to lower levels of body dissatisfaction documented in Black/African American youth compared to other ethnic minority peers.[38] However, differences in motivations were most pronounced across weight status and weight management, in which adolescents with the highest BMI and/or who were actively managing their weight expressed doctors' concern, dissatisfaction about weight, and wanting to lose weight to avoid being bullied as stronger motivations for talking about their weight with their parents than adolescents of lower weights and those not engaged in weight management, who instead reported higher motivation for engaging in weight conversations because they feel good about their weight. Adolescence is a critical period for developing positive body image and when body weight has heightened salience,[39] and our findings suggest that adolescents with higher body weight and/or who are trying to lose weight may be more likely to turn to their parents because they are distressed about their weight and related weight-based victimization. Paediatric providers can play an important role in helping parents approach these conversations using supportive communication. But, as healthcare providers themselves can also be sources of weight bias and stigmatizing communication,[40] it is important that both providers and parents carefully consider how they respond to youth to prevent communication that may unintentionally express criticism, judgement, or blame. This is especially imperative in the home setting, where opportunities for conversations about health, eating, physical activity, and physical appearance commonly occur. Rather than talking about weight, parents can choose to focus their communication on engaging in healthy behaviours, model these behaviours, and create family opportunities for physical activity and healthful eating. These parental actions not only foster a healthy home setting for both parents and their children but may help adolescents be more communicative if they feel their family environment is supportive of their health behaviours and choices.

This study has several limitations. As our study is among the first quantitative research assessing parent-adolescent motivations for weight communication, there were no validated measures to draw from. These new measures need psychometric assessment and validation. Additionally, the cross-sectional nature of our data indicates the need for longitudinal studies to investigate how motivations for weight talk may change throughout childhood and adolescence. Further, while the diversity of our sample increases generalizability of the findings, some confounding of race/ethnicity and sex was present, particularly within the parent sample; for example, while fathers comprised 30% of Black or African American parents, 66% of White parents were fathers. Additional attention should also be paid to socioeconomic status, as financial resources could shape motivations underlying parent-adolescent weight communication. Finally, as we used two unrelated, independent samples of parents and adolescents, future work should assess parent-adolescent dyads to illuminate potential bidirectional factors affecting motivations for weight communication.

5 | CONCLUSIONS

The prevalence of parental weight communication warrants a clearer understanding of the reasons why parents and adolescents engage in or avoid these conversations. Our findings indicate that parents and unrelated adolescents have multiple and different motivations for talking about weight or avoiding the topic with each other and that protecting adolescents' emotional wellbeing and body esteem are viewed as reasons for both engaging in or avoiding weight communication. Our study highlights both similarities and differences in parent and adolescent motivations for weight talk across sex, race/ethnicity, and weight status, underscoring the importance of recognizing diverse perspectives in family communication about weight.

AUTHOR CONTRIBUTIONS

Conceptualization, **Rebecca M. Puhl**; methodology, **Rebecca M. Puhl**, **Leah M. Lessard**, **Ellen V. Pudney**, **Michelle I. Cardel**; formal analysis, **Leah M. Lessard**; investigation, **Rebecca M. Puhl**, **Leah M. Lessard**; resources, **Gary D. Foster**; data curation, **Leah M. Lessard**; writing—original draft preparation, **Rebecca M. Puhl**, **Leah M. Lessard**; writing—review and editing, **Gary D. Foster**, **Michelle I. Cardel**, **Rebecca M. Puhl**, **Leah M. Lessard**, **Ellen V. Pudney**; supervision, **Rebecca M. Puhl**; project administration, **Leah M. Lessard**; funding acquisition, **Rebecca M. Puhl**. All authors have read and agreed to the published version of the manuscript.

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CONFLICT OF INTEREST

GF and MC are employees and shareholders of WW. RP has received research grants from WW and was previously a consultant to WW. LL and EP declared no conflict of interest.

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