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ORIGINAL RESEARCH

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Parent–child communication about weight: Priorities for parental education and support

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Summary

Background: Approximately 2/3 of parents talk about body weight with their children, which can include negative comments that have adverse health implications for youth.

Objectives: To identify ways to improve supportive parent–child communication about weight, we assessed parent and youth perspectives of barriers to weight communication, preferences for educational resources and support, and whether perspectives differ across demographic groups and weight status.

Methods: In Fall 2021, online surveys were completed by two independent, unrelated samples of parents ($N = 1936$) and youth ($N = 2032$). Participants were asked about their perceived barriers to talking about weight, and what kinds of information and support would be most useful to them in fostering supportive communication.

Results: Parent and youth-reported barriers to weight communication included discomfort and lack of knowledge about weight, and views that weight does not need to be discussed. Most parents wanted guidance on how to navigate multiple weight-related topics with their children, including promoting positive body image and healthy behaviours, reducing weight criticism, focusing more on health and addressing weight-based bullying. Youth preferences for how their parents can be more supportive of their weight included avoiding weight-related criticism and pressures, increasing sensitivity and encouragement, and emphasizing healthy behaviours rather than weight. Few differences emerged based on sex and race/ethnicity, although several differences emerged for youth engaged in weight management.

Conclusion: Parent and youth perspectives indicate a need for education to help parents engage in supportive conversations about body weight. Findings can inform efforts to reduce barriers and increase supportive weight-related communication in families.

KEYWORDS
adolescent, barriers, communication, parent, weight

Evidence has established the importance of parental involvement in promoting weight-related health for youth and adolescents.[1–3] Multiple parent-level factors influence their children's diet, physical activity and attitudes toward body weight and health.[1–3] Central to these parental efforts is how parents communicate about weight-related health. Approximately 2/3 of parents engage in weight-related communication with their children, including expressing both positive and negative comments about their child's weight status and/or body size.[4,5] Positive parental comments may emphasize body acceptance and/or the importance of health rather than weight,[5] whereas

negative parental weight communication includes critical comments, judgmental remarks or teasing about their child's body weight or size.[6–8]

While parental motivations for engaging in weight communication may stem in part from positive intentions to protect their children's body esteem and/or to promote body acceptance,[9] many youth across diverse body sizes do not want to talk about their body weight with parents. Recent evidence suggests that as many as 44% and 63% of adolescents never want their mothers and fathers, respectively, to talk about their weight,[5] and 53% avoid these conversations, typically because it makes them feel embarrassed or upset about their weight.[9]

Increasingly, studies have highlighted negative health implications of parental weight communication for youth. Parental weight-focused conversations are consistently associated with heightened psychological distress, dieting, unhealthy weight control practices and obesity.[10] A 2021 systematic review found adverse physical, social and psychological consequences of parental weight communication for adolescents, including body dissatisfaction, unhealthy weight control behaviours, and higher BMI.[8] These links appear to be long-lasting, with negative health outcomes associated with parental weight-focused conversations persisting beyond adolescence into adulthood.[11–13]

Collectively, this literature suggests a need for increased parental awareness about the potentially detrimental influence of their weight-focused comments, and education to help parents engage in supportive communication with their children.[12,14,15] However, little research has directly assessed what information and resources parents view to be most needed in this context. To date, studies have examined parental perspectives of how healthcare providers communicate about their child's weight,[16,17] rather than on what information or guidance parents want to improve their own communication about weight with their child. Likewise, while studies have documented adolescent perspectives of how their parents communicate to them about body weight,[4,18] lacking is assessment of adolescent perceptions of barriers in parental weight communication or their preferences for ways their parents can be more supportive about their weight. Seeking input from both parents and youth is needed to guide educational priorities, identify key objectives for resource development, and inform pediatric providers about what guidance may be most useful when advising families on engaging in effective discussions about weight-related health.

To address these research gaps, this study aimed to identify parent and youth perspectives of barriers to parent–child weight communication and priorities for educational resources and support. Using two diverse, independent samples of parents and youth, we surveyed parents to identify barriers in communicating about weight with youth and their preferences for resources to guide them in talking about weight with their child. We surveyed youth about their perceived barriers for communicating about weight with their parents, and how they want their parents to be supportive of them when it comes to their weight. Furthermore, we examined differences in parent and youth responses across sex, race/ethnicity, parental education, as well as child weight status and engagement in weight management.

1 | METHODS

1.1 | Participants and study procedures

The Institutional Review Board at the University of Connecticut approved all study procedures. Between October–December 2021, participants were recruited through Qualtrics Panel Services (a national survey panel company that aggregates 20+ online sample providers with access to several million people across all 50 states) inviting them to complete an anonymous online survey about how parents and teens talk about weight. To maximize representativeness, Qualtrics' sample providers randomly select respondents for surveys where they are likely to qualify, and directs panellists by matching qualifying demographic information from their panellist profiles. To ensure data integrity, Qualtrics checks every IP address and uses deduplication technology. Qualtrics advertised the survey to adolescents and parents using a range of web-based sources including customer loyalty web portals, social media advertisements, member referrals, targeted email lists, and messages in mobile applications. Survey invitations described the time needed for survey completion and available incentives for participation. Quotas were established to obtain sample distributions with approximately equal numbers for gender (i.e., male, female) and for race/ethnicity (i.e., Black or African American, White, Latino/a or Hispanic). Weight status distributions were also obtained for the parent and adolescent samples to approximate national averages, thus both samples included participants of diverse body sizes. Written informed consent was provided by participants (parents of youth aged 10–12 provided their consent). For hard-to-reach groups, Qualtrics utilizes their partner network and niche panels generated through specialized recruitment campaigns. Participants were compensated for their participation with incentives offered by Qualtrics (e.g., cash, gift cards, redeemable points, vouchers). Individuals with missing/implausible BMI data, mischievous responses (e.g., duplicate or invalid IP address, bot detection) and/or outside the eligible age range (i.e., parent of child aged 10–17 or child aged 10–17 years) were excluded (parent sample $n = 184$; adolescent sample $n = 298$).

2 | MEASURES

2.1 | Demographic and weight-related characteristics

Parents self-reported their sex, age, race/ethnicity, educational attainment, and their child's demographic information and height/weight, as well as whether their child has tried to lose weight or keep from gaining weight in the past year (yes/no). Youth self-reported their sex, race/ethnicity, age (year and month born), sexual orientation, parental level of education, current height and weight, and weight management status (i.e., whether they have tried to lose weight or keep from gaining weight in the past year). The Centers for Disease Control and

Prevention growth charts were used to calculate body mass index (BMI) percentiles for age and sex.[19]

2.2 | Perceived barriers to weight communication

Parental perceptions of barriers to weight communication were assessed by asking parents their level of agreement (1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree) with five statements, such as "I don't feel comfortable talking about weight with my child." Item wording was modelled from prior measures assessing parent–adolescent communication about sex.[20] To assess youth perceptions of barriers to weight communication, youth provided their level of agreement with five similarly-worded statements (oriented toward their parents), such as "I don't feel comfortable talking about weight with my parent(s)." Tables 2 and 3 display all items and summarize the percentage of participants who responded "agree" or "strongly agree" to each item.

2.3 | Preferences for resources and support

To assess parental preferences for resources to guide their communication on weight-related topics with their child, parents were provided with the following instructions: "The topic of body weight can be difficult to navigate as a parent. Please indicate whether information or resources would be useful to you on the following topics". Parents then responded with "yes" or "no" to 14 different topic areas, such as "ways to help my child feel supported at home when it comes to his/her body weight" (see Table 4, which depicts the percentage of parents responding "yes" to each item). To assess youth preferences for parental support, youth were asked "When it comes to your weight, how do you want your parent(s) to be supportive of you?" Youth were provided with 20 statements (e.g., "I want my parent(s) to try to understand how I feel about my weight and size") and asked to indicate their preference for each supportive parental action on a 5-point Likert Scale (1 = No, definitely not; 2 = Probably not; 3 = Possibly; 4 = Probably; 5 = Yes, definitely); see Table 5. Development of these survey questions for adolescents and parents was informed by the broader quantitative and qualitative literature examining parent and adolescent experiences and perspectives of engaging in weight communication,[8,21,22] and from prior research examining adolescent preferences for weight-based terminology and desired support from family members to cope with weight-based stigma.[18,23,24]

2.4 | Analytic plan

Prevalence rates of barriers to parental weight communication and parent-reported preferences for resources related to body weight are presented; chi-square tests were used to examine differences as a function of sex (parents: fathers/mothers; youth: boys/girls), racial/ethnic (white/Black or African American/Latinx), parental education (no college degree/college degree), child weight status (BMI <5th percentile/BMI 5–84.9th percentile/BMI 85–94.9th percentile/BMI ≥95th percentile) and child weight management (has vs. has not engaged in weight management in the past year). Mean ratings of youth-reported preferences for weight-related support from their parents are subsequently provided; demographic and weight status differences were tested using a series of one-way analyses of variance (ANOVA). All analyses were conducted using SPSS (version 28) and statistical significance was set at $p < 0.01$ to reduce the likelihood of Type 1 error.

3 | RESULTS

3.1 | Characteristics of the samples

Table 1 reports characteristics of the two independent U.S.-based samples: parents with children aged 10–17 years old ($N = 1936$), and a separate sample of youth between the ages of 10 and 17 ($N = 2032$). Additional details about the sample characteristics are reported elsewhere.[5]

TABLE 1 Characteristics of parent and adolescent samples.

	Parent sample ($N = 1936$) %	Adolescent sample ($N = 2032$) %
Sex		
Male	48.1	40.6
Female	51.6	59.4
Other[a]	0.3	--
Race/Ethnicity		
White, non-Hispanic, non-Latino	31.9	40.2
Black or African American	32.5	24.7
Latinx, Hispanic, or Mexican-American	31.3	23.4
Other (e.g., Multiethnic, Asian, Alaska Native)	4.2	11.7
(Parental) Level of education[b]		
College degree (or above)	45.4	34.9
No college degree	54.6	65.1
(Child) Weight management[c]		
No	47.9	46.5
Yes	52.1	53.5

Note: Due to rounding, percentages do not always add up to 100.
[a]"Other" option provided only among parent sample.
[b]Among parent sample, reflective of participants highest level of education. Among adolescent sample, participants were asked to report the highest level of education of their primary caregiver.
[c]Among parent sample, reflective of the child parent participants completed the questionnaire about. Among adolescent sample, reflective of participants' own characteristics and experiences.

TABLE 2 Parent-reported barriers to parental weight communication.

	Total sample	Sex		Race/Ethnicity			Parental education		Child weight status				Child weight management	
	%	Fathers %	Mothers %	White %	Black or African American %	Latinx %	No college degree %	College degree %	BMI <5th percentile %	BMI 5–84.9th percentile %	BMI 85–94.9th percentile %	BMI ≥95th percentile %	No %	Yes %
1. I do not know enough about weight to talk to my child about it.	31	38[a]	25[b]	27[a]	23[a]	45[b]	27[a]	36[b]	32[a]	24[a]	28[a]	49[b]	21[a]	40[b]
2. I do not feel comfortable talking about weight with my child.	31	38[a]	23[b]	30[a]	21[b]	42[c]	24[a]	38[b]	28[a]	24[a]	27[a]	48[b]	21[a]	40[b]
3. I do not think I need to talk to my child about weight.	46	50[a]	41[b]	47[a]	37[b]	52[a]	44[a]	48[a]	47[a]	44[a]	42[a]	50[a]	49[a]	42[b]
4. My child already knows what they need to know about weight.	65	68[a]	63[b]	69[a]	60[b]	67[ab]	63[a]	68[a]	64[a]	66[a]	62[a]	66[a]	66[a]	65[a]
5. I think that talking to my child about body positivity will only encourage them to gain weight.	37	45[a]	30[b]	39[a]	29[b]	46[a]	30[a]	46[b]	37[a]	32[a]	34[a]	52[b]	26[a]	48[b]

Note: Values reflect the percent of parents responding "agree" or "strongly agree" to each item. Values within the same row and subgrouping not sharing the same letter (e.g., a vs b; b vs c) are significantly different from each other at $p < 0.01$.

TABLE 3 Adolescent-reported barriers to parental weight communication.

	Total Sample	Sex		Race/Ethnicity			Parental education		Weight status				Weight management	
	%	Boys %	Girls %	White %	Black or African American %	Latinx %	No college degree %	College degree %	BMI <5th percentile %	BMI 5–84.9th percentile %	BMI 85–94.9th percentile %	BMI ≥95th percentile %	No %	Yes %
1. My parent(s) think that they do not know enough about weight to talk to me about it.	30	34[a]	27[b]	29[a]	29[a]	37[b]	25[a]	33[b]	39[a]	29[a]	30[a]	31[a]	21[a]	38[b]
2. I do not feel comfortable talking about weight with my parent(s).	46	42[a]	49[b]	44[a]	42[a]	54[b]	44[a]	51[b]	53[ab]	44[a]	40[a]	54[b]	35[a]	56[b]
3. My parent(s) think they do not need to talk to me about weight.	43	47[a]	41[b]	42[a]	42[a]	45[a]	41[a]	48[b]	48[ab]	45[a]	45[a]	36[b]	45[a]	42[a]
4. I already know what I need to know about weight.	27	30[a]	25[a]	26[a]	27[ab]	34[b]	67[a]	71[a]	36[a]	25[a]	27[a]	30[a]	20[a]	33[b]
5. 5. My parent(s) think that talking to me about accepting my body as it is will only encourage me to gain weight.	67	68[a]	68[a]	68[a]	66[a]	71[a]	27[a]	36[b]	66[ab]	71[a]	70[ab]	62[b]	69[a]	68[a]

Note: Values reflect the percent of adolescents responding "agree" or "strongly agree" to each item. Values within the same row and subgrouping not sharing the same letter (e.g., a vs b) are significantly different from each other at $p < 0.01$.

TABLE 4 Parent-reported preferences for resources related to body weight.

The topic of body weight can be difficult to navigate as a parent. Please indicate whether information or resources would be useful to you on the following topics:	Total sample	Sex		Race/Ethnicity			Parental education		Child weight status				Child weight management	
	%	Fathers %	Mothers %	White %	Black or African American %	Latinx %	No college degree %	College degree %	BMI <5th percentile %	BMI 5–84.9th percentile %	BMI 85–94.9th percentile %	BMI ≥95th percentile %	No %	Yes %
1. How to help my child have more positive body image and body esteem.	68	72[a]	64[b]	70[a]	61[b]	73[a]	64[a]	72[b]	65[a]	64[a]	68[a]	78[b]	57[a]	78[b]
2. Strategies to help me support my child in making healthy behaviour changes.	63	61[a]	64[a]	63[a]	63[a]	62[a]	61[a]	65[a]	61[a]	64[a]	64[a]	60[a]	56[a]	69[b]
3. How to develop a healthier body image for myself.	63	60[a]	65[a]	65[a]	63[a]	61[a]	63[a]	62[a]	64[a]	64[a]	61[a]	61[a]	58[a]	67[b]
4. How to focus conversations with my child more on health, rather than weight.	62	62[a]	62[a]	63[a]	58[a]	64[a]	61[a]	64[a]	60[a]	63[a]	62[a]	62[a]	54[a]	70[b]
5. Ways to help my child feel supported at home when it comes to his/her weight.	61	61[a]	62[a]	60[a]	59[a]	65[a]	60[a]	62[a]	56[a]	61[a]	64[a]	63[a]	53[a]	69[b]
6. How to identify signs of whether my child is being teased or bullied about weight.	61	62[a]	61[a]	62[a]	58[a]	63[a]	59[a]	63[a]	60[a]	60[a]	64[a]	64[a]	54[a]	68[b]
7. Ways to help me talk to my child about body weight and appearance.	59	65[a]	54[b]	61[a]	51[b]	66[a]	53[a]	66[b]	57[a]	55[a]	61[ab]	69[b]	44[a]	73[b]
8. How to help my child accept his/her own body size.	59	59[a]	60[a]	56[a]	59[a]	63[a]	58[a]	61[a]	60[a]	58[a]	57[a]	63[a]	51[a]	67[b]
9. What steps I can take if my child is being teased or bullied about weight at school.	59	59[a]	59[a]	59[a]	56[a]	60[a]	57[a]	60[a]	62[a]	58[a]	61[a]	59[a]	52[a]	65[b]
10. Strategies to help me talk to my child about weight-based teasing or bullying.	58	58[a]	57[a]	57[a]	54[a]	61[a]	55[a]	61[b]	56[ab]	55[a]	61[ab]	64[b]	49[a]	66[b]
11. How to be less critical of my own weight or body size.	55	53[a]	60[b]	55[ab]	54[a]	61[b]	57[a]	57[a]	56[a]	55[a]	59[a]	60[a]	50[a]	63[b]
12. How to address weight criticism or teasing from other family members.	55	54[a]	55[a]	53[a]	54[a]	58[a]	53[a]	57[a]	48[a]	53[a]	59[ab]	61[b]	44[a]	64[b]
13. How to talk to my child about weight-related topics on social media.	54	57[a]	51[b]	57[a]	48[b]	57[a]	49[a]	60[b]	58[a]	51[a]	57[a]	55[a]	45[a]	62[b]
14. How to be less critical of my child's weight or body size.	47	50[a]	45[a]	44[a]	45[a]	53[b]	44[a]	52[b]	43[ab]	46[a]	46[ab]	54[b]	38[a]	56[b]

Note: Values reflect the percent of parents responding "yes" to each item. Values within the same row and subgrouping not sharing the same letter (e.g., a vs b) are significantly different from each other at $p < 0.01$.

TABLE 5 Adolescent-reported preferences for weight-related support from their parents.

	Total sample	Sex		Race/Ethnicity			Parental education		Weight status				Weight management	
I want my parent(s) to:	*M (SD)*	Boys *M (SD)*	Girls *M (SD)*	White *M (SD)*	Black or African American *M (SD)*	Latinx *M (SD)*	No college degree *M (SD)*	College degree *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. Avoid making critical comments about my weight or appearance.	3.88 (1.28)	3.75^{a} (1.28)	3.97^{b} (1.27)	3.99^{a} (1.22)	3.70^{b} (1.36)	3.85^{ab} (1.27)	3.79^{a} (1.35)	4.07^{b} (1.12)	3.83^{ab} (1.30)	3.82^{a} (1.32)	3.86^{ab} (1.29)	4.02^{b} (1.19)	3.85^{a} (1.32)	3.91^{a} (1.25)
2. Not pressure me to look a certain way.	3.85 (1.31)	3.76^{a} (1.30)	3.91^{a} (1.31)	3.95^{a} (1.27)	3.73^{b} (1.39)	3.80^{ab} (1.25)	3.79^{a} (1.37)	3.97^{b} (1.17)	3.58^{a} (1.38)	3.81^{ab} (1.34)	3.87^{ab} (1.31)	3.97^{b} (1.21)	3.85^{a} (1.34)	3.85^{a} (1.28)
3. Make it easier to be healthier at home (e.g., have healthy foods available).	3.84 (1.23)	3.79^{a} (1.19)	3.87^{a} (1.26)	3.86^{a} (1.20)	3.70^{a} (1.34)	3.87^{a} (1.18)	3.73^{a} (1.28)	4.03^{b} (1.09)	3.69^{ab} (1.31)	3.78^{a} (1.25)	3.80^{ab} (1.24)	4.00^{b} (1.17)	3.76^{a} (1.26)	3.90^{a} (1.20)
4. Use words that I feel comfortable with when talking about my weight.	3.83 (1.24)	3.78^{a} (1.18)	3.86^{a} (1.27)	3.87^{a} (1.20)	3.75^{a} (1.29)	3.85^{a} (1.21)	3.73^{a} (1.31)	4.00^{b} (1.07)	3.84^{a} (1.27)	3.77^{a} (1.27)	3.90^{a} (1.17)	3.90^{a} (1.19)	3.78^{a} (1.25)	3.87^{a} (1.22)
5. Encourage me when I feel down about my weight or appearance.	3.80 (1.28)	3.78^{a} (1.23)	3.82^{a} (1.32)	3.85^{a} (1.25)	3.70^{a} (1.35)	3.84^{a} (1.25)	3.70^{a} (1.33)	3.96^{b} (1.18)	3.70^{ab} (1.35)	3.72^{a} (1.30)	3.91^{ab} (1.23)	3.93^{b} (1.25)	3.80^{a} (1.28)	3.80^{a} (1.29)
6. Not lecture me about what I eat.	3.78 (1.33)	3.64^{a} (1.33)	3.87^{b} (1.31)	3.85^{a} (1.31)	3.67^{a} (1.39)	3.73^{a} (1.28)	3.72^{a} (1.37)	3.90^{b} (1.22)	3.77^{ab} (1.32)	3.69^{a} (1.35)	3.78^{ab} (1.34)	3.96^{b} (1.24)	3.70^{a} (1.38)	3.85^{a} (1.27)
7. Focus more on me being healthy, not how much I weigh.	3.78 (1.26)	3.74^{a} (1.22)	3.81^{a} (1.29)	3.82^{a} (1.21)	3.65^{a} (1.37)	3.82^{a} (1.21)	3.71^{a} (1.31)	3.91^{b} (1.17)	3.79^{a} (1.29)	3.78^{a} (1.26)	3.76^{a} (1.30)	3.80^{a} (1.24)	3.77^{a} (1.28)	3.79^{a} (1.25)
8. Encourage me or praise me for my healthy habits.	3.78 (1.28)	3.83^{a} (1.20)	3.75^{a} (1.33)	3.81^{a} (1.25)	3.71^{a} (1.37)	3.80^{a} (1.21)	3.71^{a} (1.33)	3.90^{b} (1.18)	3.87^{a} (1.26)	3.71^{a} (1.31)	3.88^{a} (1.23)	3.85^{a} (1.26)	3.79^{a} (1.27)	3.77^{a} (1.29)
9. Help me find clothes that look good for my body type.	3.75 (1.26)	3.79^{a} (1.20)	3.73^{a} (1.30)	3.80^{a} (1.22)	3.67^{a} (1.35)	3.79^{a} (1.21)	3.66^{a} (1.31)	3.92^{b} (1.15)	3.65^{ab} (1.35)	3.70^{a} (1.28)	3.77^{ab} (1.22)	3.88^{b} (1.24)	3.75^{a} (1.25)	3.75^{a} (1.27)
10. Be open to talking about my weight if I bring it up.	3.74 (1.25)	3.81^{a} (1.22)	3.70^{a} (1.27)	3.81^{a} (1.20)	3.63^{a} (1.34)	3.83^{a} (1.16)	3.69^{a} (1.29)	3.82^{a} (1.16)	3.91^{ab} (1.11)	3.68^{a} (1.26)	3.69^{ab} (1.28)	3.88^{b} (1.21)	3.77^{a} (1.26)	3.72^{a} (1.24)
11. Not lecture me about getting enough exercise.	3.73 (1.32)	3.64^{a} (1.31)	3.79^{a} (1.33)	3.86^{a} (1.28)	3.59^{b} (1.39)	3.66^{b} (1.28)	3.66^{a} (1.36)	3.86^{b} (1.23)	3.67^{ab} (1.29)	3.65^{a} (1.35)	3.80^{ab} (1.36)	3.86^{b} (1.25)	3.71^{a} (1.35)	3.74^{a} (1.30)

(Continues)

TABLE 5 (Continued)

	Total sample	Sex		Race/Ethnicity			Parental education		Weight status				Weight management	
I want my parent(s) to:	*M (SD)*	Boys *M (SD)*	Girls *M (SD)*	White *M (SD)*	Black or African American *M (SD)*	Latinx *M (SD)*	No college degree *M (SD)*	College degree *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)*
12. Avoid blaming me for my weight.	3.73 (1.32)	3.62[a] (1.34)	3.80[b] (1.30)	3.78[a] (1.28)	3.61[a] (1.41)	3.74[a] (1.30)	3.63[a] (1.38)	3.92[b] (1.20)	3.85[ab] (1.28)	3.64[a] (1.35)	3.73[ab] (1.32)	3.89[b] (1.26)	3.62[a] (1.37)	3.82[b] (1.27)
13. Help me be at a healthy weight.	3.69 (1.26)	3.77[a] (1.21)	3.63[a] (1.30)	3.72[a] (1.25)	3.62[a] (1.33)	3.73[a] (1.19)	3.60[a] (1.31)	3.85[b] (1.15)	3.53[ab] (1.45)	3.63[a] (1.27)	3.71[ab] (1.23)	3.83[b] (1.21)	3.66[a] (1.27)	3.71[a] (1.26)
14. Help me find answers to questions that I have about weight.	3.62 (1.31)	3.70[a] (1.27)	3.57[a] (1.34)	3.69[a] (1.28)	3.60[a] (1.34)	3.56[a] (1.29)	3.56[a] (1.35)	3.74[b] (1.23)	3.77[ab] (1.28)	3.53[a] (1.33)	3.64[ab] (1.30)	3.78[b] (1.27)	3.60[a] (1.32)	3.65[a] (1.30)
15. Help me deal with being teased about my weight or appearance.	3.60 (1.34)	3.57[a] (1.30)	3.61[a] (1.37)	3.67[a] (1.30)	3.58[a] (1.36)	3.58[a] (1.31)	3.51[a] (1.39)	3.74[b] (1.24)	3.56[ab] (1.35)	3.54[a] (1.37)	3.57[ab] (1.36)	3.75[b] (1.26)	3.60[a] (1.36)	3.59[a] (1.33)
16. Listen more to me when I express my thoughts and feelings about my body.	3.53 (1.30)	3.51[a] (1.24)	3.55[a] (1.35)	3.55[a] (1.28)	3.43[a] (1.39)	3.61[a] (1.22)	3.43[a] (1.34)	3.72[b] (1.21)	3.52[ab] (1.26)	3.45[a] (1.34)	3.47[a] (1.28)	3.75[b] (1.23)	3.41[a] (1.34)	3.65[b] (1.26)
17. Help me to feel better about my body.	3.50 (1.34)	3.41[a] (1.30)	3.56[a] (1.35)	3.49[a] (1.30)	3.43[a] (1.40)	3.59[a] (1.26)	3.39[a] (1.38)	3.69[b] (1.23)	3.55[ab] (1.36)	3.41[a] (1.36)	3.53[ab] (1.31)	3.66[b] (1.28)	3.33[a] (1.36)	3.64[b] (1.30)
18. Avoid talking about my weight unless I want to talk about it.	3.50 (1.33)	3.41[a] (1.31)	3.55[a] (1.35)	3.55[a] (1.31)	3.34[b] (1.40)	3.56[ab] (1.28)	3.41[a] (1.37)	3.66[b] (1.24)	3.50[ab] (1.27)	3.43[a] (1.37)	3.41[a] (1.30)	3.70[b] (1.28)	3.34[a] (1.37)	3.64[b] (1.29)
19. Ask me if I have questions about body weight.	3.46 (1.34)	3.51[a] (1.29)	3.43[a] (1.36)	3.49[a] (1.31)	3.46[a] (1.37)	3.47[a] (1.29)	3.39[a] (1.38)	3.59[b] (1.24)	3.65[a] (1.29)	3.38[a] (1.35)	3.50[a] (1.33)	3.56[a] (1.31)	3.46[a] (1.36)	3.46[a] (1.32)
20. Try to understand how I feel about my weight and size.	3.45 (1.28)	3.44[a] (1.24)	3.46[a] (1.31)	3.47[a] (1.27)	3.36[a] (1.34)	3.50[a] (1.19)	3.33[a] (1.32)	3.66[b] (1.16)	3.47[ab] (1.36)	3.35[a] (1.29)	3.48[ab] (1.27)	3.62[b] (1.23)	3.30[a] (1.31)	3.58[b] (1.24)

Note: Item response values as follows: 1 = *no, definitely not*; 2 = *probably not*; 3 = *possibly*; 4 = *probably*; 5 = *yes, definitely*. Values within the same row and subgrouping not sharing the same letter (e.g., a vs b) are significantly different from each other at $p < 0.01$.

3.2 | Barriers to parent–child weight communication

Most parents (65%) indicated that their child already knows enough about body weight, and 46% reported that they do not feel the need to talk to their child about weight. However, 31% of parents reported that they themselves do not know enough about weight or feel comfortable enough to talk about it with their child, and 37% expressed concerns that talking about body positivity would encourage weight gain in their child (see Table 2). Parental agreement with these communication barriers differed across sex, race/ethnicity and their child's weight status. Compared to mothers, significantly more fathers expressed agreement with all five barriers. Compared to white parents, a higher percentage of parents identifying as Latinx indicated that they do not know enough about weight or feel comfortable enough to talk about it with their child, whereas a lower percentage of Black/African American parents reported these views. In addition, a higher percentage of parents with versus without a college degree reported that they do not know enough about weight to talk to their child about it, that they do not feel comfortable talking about weight with their child, and that they think that talking to their child about body positivity will only encourage them to gain weight. Finally, compared to parents with lower weight children, significantly more parents of youth with BMI ≥95th percentile or engaged in weight management reported not knowing enough about weight or feeling comfortable enough to talk about it with their child.

Among youth, almost half (46%) reported that they do not feel comfortable talking to their parents about weight, and 27% indicated that they already know enough about weight. Most youth (67%) reported that their parents think that talking about body acceptance will encourage them to gain weight, and that their parents feel that they do not need to talk about weight (43%) or do not know enough about weight to talk about it (30%). More girls than boys were uncomfortable talking about weight with their parents, as were Latinx youth, those with a college educated parent, those with the highest BMI, youth engaged in weight management compared to White and Black/African American youth, those without a college educated parent, and those with lower BMI and not engaged in weight management (see Table 3).

3.3 | Parental preferences for resources

The majority of parents (54%–68%) indicated that it would be useful to have information and resources on 13 of the 14 topic areas presented to them (see Table 4), particularly for strategies to help improve their child's body image, support their child in making healthy behaviour changes, focus conversations more on health than weight and help their child feel more supported about their weight at home. Across all 14 topic areas, the highest percentage of parents who indicated that these resources would be useful were those with a child engaged in weight management. Few differences emerged between mothers and fathers, with the exception that more fathers than mothers indicated that resources would be useful on how to promote their child's body image, and ways to talk to their child about weight, appearance, and weight-related topics on social media. More mothers than fathers felt that it would be useful for resources to help them be less critical of their own weight. Similarly, few differences emerged across race/ethnicity, with the exception that more White and Latinx parents (compared to Black/African American parents) would like resources to help their child have more positive body image, and ways to talk to their child about weight, appearance, and weight-related topics on social media.

3.4 | Youth preferences for parental support

Youth ratings were generally consistent across the 20 supportive parental actions presented to them, with mean ratings ranging from 3.45 to 3.88 (out of 5; see Table 5). Youth expressed the strongest preference for parents to avoid making critical comments about their weight or appearance or pressuring them to look a certain way; to use weight terminology that they feel comfortable with; to make it easier to be healthier at home; and to encourage them when they feel down about their weight. There were no sex differences in preferences for parental support, with the exception that girls indicated a stronger preference for parents to avoid lecturing them about what they eat, avoid making critical comments about their weight or appearance, and not blame them for their weight compared to boys. Similarly, few differences emerged across race/ethnicity, with the exception that white youth expressed stronger preferences for parents to avoid making critical comments about their weight or appearance, not pressuring them to look a certain way, or talking about their weight unless they want to talk about it compared to Black/African American youth. Differences were most pronounced across parental education; specifically, youth with versus without a college educated parent expressed stronger preference for each type of weight-related support from their parents (with the exception of parents being open to talking about their weight if they bring it up). Some differences emerged across weight status of youth, with stronger preferences for parental support typically endorsed by those at the highest BMI percentile. Furthermore, youth who were engaged in weight management expressed stronger preferences for their parents not blaming them for their weight, avoiding the topic unless they want to talk about it, helping them feel better about their body, and listening to them and trying to understand their feelings about their body size.

4 | DISCUSSION

In this study, we asked parents and youth what they perceive as barriers to talking about weight and what kinds of information and support would be most useful in fostering positive and supportive communication. Their perspectives are key in identifying priorities to help inform content, goals, and objectives of educational efforts and resources to support optimal weight-related communication in

families. Our findings suggest several differences and similarities in parent and youth perceptions of potential barriers in weight communication. First, while 65% of parents reported that they feel their child already knows what they need to know about weight, only 27% of youth reported that they know enough on this topic. This suggests that parents may be overestimating youths' knowledge about weight-related health issues. Furthermore, given that approximately one-third of both parents and youth indicated that they do not know enough about weight to talk about it, these knowledge gaps may pose hesitancy or avoidance in family discussions about weight-related health. This may, in part, explain why almost half of youth and a third of parents reported they do not feel comfortable talking about weight. It is also likely that discomfort stems from parental concerns about damaging their child's self-esteem[9,25] and youths' feelings of embarrassment or distress related to their body size.[9] As discomfort was reported most by youth with high BMI and those involved in weight management, helping parents of these youth engage in supportive communication is particularly warranted. Discomfort with weight communication was also higher in Latinx youth; recent evidence suggests that these youth report feeling more upset when talking about weight with parents compared to white or Black youth,[9] and that Latinx parents tend to engage in more frequent weight communication than parents of other racial/ethnic groups.[5] More research is needed to identify the nature and context of communication barriers within Latinx families.

Additionally, our findings offer initial insights on parental perspectives of body positivity as a potential barrier in the context of weight communication. Body positivity emphasizes accepting and appreciating one's body (instead of being critical) and promoting body esteem, but more than a third of parents felt that if they talk to their child about body positivity it will only encourage their child to gain weight. The majority of youth (67%) agreed that their parents view body acceptance in this way. This finding suggests that more research is warranted to better understand parental views and knowledge of body acceptance. Additionally, parents may benefit from education about the health consequences of weight stigma and discrimination (including poorer mental health, maladaptive eating behaviours and weight gain)[26,27] versus the health benefits associated with body acceptance and appreciation among adolescents, such as increased physical fitness,[28] intuitive eating and lower substance use.[29]

Parental interest in guidance for ways to navigate weight-related issues with their child was evident in our study. Most parents indicated information on 13 topic areas would be useful, ranging from promoting body image in their child (and themselves), to shifting conversations about health rather than weight, supporting their child in engaging in healthy behaviours, reducing weight criticism at home, and determining if their child is being teased or bullied about weight. Parental interest in resources on these topics was largely consistent across sex, race/ethnicity and child weight status, suggesting that these issues broadly affect diverse families. Moreover, these findings imply that most parents do not have adequate information on these topics, reflecting an unmet need. Thus, our findings suggest the importance of developing educational resources for parents on a variety of weight-related topics affecting youth, and making these resources accessible and available to parents. Disseminating these resources to pediatric providers would provide opportunities for them to share this information with parents and discuss ways for parents to approach to conversations about weight-related health using supportive, non-judgmental communication. Finally, it is noteworthy that parents of children across the BMI spectrum (<5th percentile to ≥95th percentile) expressed barriers to talking about weight with their child, and there were relatively few differences in parental preferences for resources based on their child's weight status. These findings suggest that parents with children of all body sizes feel that weight is a vulnerable topic. Given the presence of societal weight stigma in our culture,[30] and that weight-based teasing can be directed toward youth of diverse body sizes,[31] it is important that resource development and provider discussions promoting supportive communication target families across the spectrum of body shapes and sizes.

Youth in our study identified multiple ways that they want their parents to be supportive of them when it comes to their body weight, some which overlap with topic areas that parents want more guidance on. Salient among youth preferences were parents to avoid weight-related criticism, blame and pressures on adolescents, and to, instead, focus on sensitive and encouraging communication, healthy behaviours rather than weight, creating opportunities to be healthy at home and listening to their feelings. Few differences emerged in these preferences across youth sex, race/ethnicity or engagement in weight management, suggesting that youth of diverse body sizes and backgrounds desire parents to be more supportive of their body weight. These findings reiterate the need for parental education and resources on multiple weight-related topics, and for guidance on how parents can be less critical and more sensitive to their child's feelings about their body size. Pediatric providers can play an important role in modelling supportive communication and educating parents in this context, which aligns with recommendations from the American Academy of Pediatrics for pediatric health professionals to engage parents on ways to address weight stigma and its impact on youth in the home environment.[32]

Our study has several strengths including racially/ethnically diverse samples of parents and youth, with diverse weight categories, and both males and females. Additionally, our item-level analyses provide specificity with respect to particular barriers present in parent-youth communication, key topics for parental education and adolescent preferences for parental support, all of which are informative for the development of targeted resources for families and supportive care approaches. However, several limitations are present. Although our samples are diverse with respect to gender, race/ethnicity, and body size of participants and resemble national distributions, they are not nationally representative samples. It will be important for future studies to assess generalizability of our findings across other samples of parents and adolescents. We used independent samples of parents and adolescents, and future research should study parent–child dyads. We relied on self-report cross-sectional data and cannot make

inferences about familial weight communication over time. Given the lack of prior work examining parent and youth perspectives about barriers or ways to improve weight-related communication, there were no validated measures to draw from and future studies should examine psychometric assessment of these constructs.

5 | CONCLUSIONS

Discomfort, lack of knowledge and preconceptions about body weight may pose barriers in parent–child weight communication. Parents identified multiple topics they would like guidance on for talking about weight with their children, particularly for promoting positive body image, reducing weight criticism, focusing more on health and addressing weight-based teasing. Youth preferences for ways their parents can be more supportive similarly highlight the need for parents to avoid weight-related criticism and pressures, and increase sensitivity, encouragement and an emphasis on healthy behaviours. Our study highlights more similarities than differences in parent and youth perspectives across sex, race/ethnicity and child weight status, underscoring a broad need for education and resources to help parents navigate conversations about body weight. These findings can inform efforts to reduce barriers and increase supportive communications about weight-related health within families.

AUTHOR CONTRIBUTIONS

Conceptualization: Rebecca M. Puhl; Methodology: Rebecca M. Puhl, Leah M. Lessard, 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; 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 STATEMENT

Gary D. Foster and Michelle I. Cardel are employees and shareholders of WW. Rebecca M. Puhl has received research grants from WW and was previously a consultant to WW. Leah M. Lessard declared no conflicts of interest.

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