Preferred Language for Weight-Inclusive Conversations with Youth and Their Families*

	Instead of This	Try This	Why It Matters
Free from stigma & person-first	▪ Overweight ▪ Obese ▪ Fat	Ask the patient what language they prefer to use: "How do you prefer to talk about your body size/shape?" "What words do you use or at home?" Some examples: ▪ BMI is X ▪ Larger body ▪ Higher weight ▪ Plus size	Medical terms including overweight and obesity are often not preferred and can be viewed as very charged terms. Using these terms could result in medical avoidance, defensiveness, and a strong desire/urge to exit the conversation.[1]
Neutral, non-judgmental, and based on facts, actions, or physiology/biology	▪ Ideal weight ▪ Goal weight ▪ "Your preferred weight is..." ▪ "Your ideal weight is..."	▪ "Your weight is..." ▪ "Your BMI is X" ▪ "Your BMI is higher than X..."	Terms like "ideal weight", "goal weight", etc. are judgmental and convey a false belief that there is a single, universal weight that prevents illness. It does not account for the individual's personal or health goals. Instead, consider focusing on specific habits/behaviors over which the patient does have control rather than making goals about weight. Focusing only on weight can result in feelings of failure when the patient is unable to meet weight goals despite significant efforts. Many behaviors result in improved health markers regardless of weight change.[2]
Avoids unintended consequences or mixed messages	Unsolicited comments on body size or body changes, either observed or measured. ▪ "Wow, you're looking great!" ▪ "Look at how much weight you've lost! I'm so proud of you!" ▪ "You're getting so big!"	▪ "If any, what are some concerns about your weight?" ▪ "How do you view or feel about your body?" ▪ "Have you experienced any significant weight changes?" ▪ If yes: ○ "How do you feel about that?" ○ "What do you think might be going on?"	Fear of comments about body size can result in feelings of shame, self-consciousness, and medical avoidance. Comments on body size, even if intended as a compliment, could trigger disordered eating, which is associated with negative health outcomes.[3] This could result in mixed messages if the weight loss is a result of hyperglycemia/glucosuria.

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Fosters collaboration between patients and providers.	▪ "Eat less, move more." ▪ "Have you tried XYZ diet/plan?" ▪ "We need to talk about your weight."	▪ "How do you feel about your eating patterns/exercise habits right now?" ▪ "One of the things that we talk about related to diabetes is body weight. Would it be alright if we talked about your weight today?" ▪ Introduce meeting with a nutrition professional: "Some of my patients have found it helpful to meet with a registered dietitian who can be a great partner to explain all of the confusing nutrition messages out there and help them feel more confident about their nutrition. Is this something you'd be interested in?" ▪ Introduce meeting with a behavioral health professional: "Behavioral medicine and psychology services are an integrated part of our team. Some patients have found it helpful to meet with a psychologist to learn skills to better navigate emotions and behaviors that may come up when living with diabetes. Some examples include learning to better cope with diabetes burn-out, remembering to take your insulin, or navigating relationships while living with diabetes. Is this something you'd be interested in?"	Behavior change is difficult; offering advice that does not acknowledge this can feel dismissive. Acknowledging individual differences and preferences as well as partnering with your patient in making behavior change goals is more likely to succeed. Weight is not a behavior. Provide guidance on specific habits/behaviors and clinical markers rather than only focusing on weight.[4] For example, exercise can improve health outcomes, mood, and quality of life regardless of weight change.[5] Ask permission to discuss weight (especially when bringing it up as a problem to be solved).[6] Bringing up topics without consent can cause significant frustration and communicates to patients a lack of collaboration between patient and provider.
Avoids placing blame on adolescent/teen	▪ "You just need to eat more fruits and vegetables, eat smaller portions, exercise X minutes a day, etc."	▪ "One change that is beneficial for all/most kids' health is to increase variety of foods. What is a new food you'd like to try? What steps can we take to increase variety of foods as a family?" ▪ [To the teen/child] "What are your thoughts about food/movement?" Then provide ideas/suggestions with permission. "Would it be ok if I shared some ideas?"	Directing behavior change action items toward youth alone is often discouraging because they have relatively little say over their food environment and/or autonomy in their food options. Engaging parents/caregivers is an important part of this process. Acknowledging that emotions can impact eating behaviors is also a key part of discussing any behavior change.

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Collaboration with caregivers (as appropriate for child's age, developmental stage)	▪ "Your child needs to lose five pounds by your next visit." ▪ "Have you tried sneaking vegetables into meals?"	▪ [To the parent/caregiver] "How can you support [child's name] in increasing movement/activity? ▪ "What is something you could do together?" ▪ "What might be some barriers that could make it challenging to make changes as a family?" ▪ "What supports/resources do you already have that can help you be successful?"	Youth often pick up the habits and behaviors that caregivers model, which is important to acknowledge and leverage. If caregivers can make behavior change with their child[ren], the likelihood of true change may increase. Collaboration with caregivers can also help illuminate socioeconomic, environmental, and mental health challenges.

*This document has been adapted from ADCES, NAAFA and the following references:

References

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