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"So, you're a lean guy": Care Provider, Parent, and Child Communication about Weight, Diet, and Physical Activity

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy

in

Public Health (Health Behavior)

by

Kyle Gutzmer

Committee in charge:

University of California San Diego

Professor Lisa Madlensky
Professor Jamila Stockman

San Diego State University

Professor Wayne Beach, Chair
Professor Guadalupe X. Ayala
Professor David Dozier

2018

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Chair

University of California San Diego

San Diego State University

2018

DEDICATION

This dissertation is dedicated to my littlest loves, Jack Benjamin and Oliver Levi.

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ABSTRACT OF THE DISSERTATION

“So, you’re a lean guy”:
Care Provider, Parent, and Child Communication about Weight, Diet, and Physical Activity

by

Kyle Gutzmer

Doctor of Philosophy in Public Health (Health Behavior)

University of California San Diego, 2018
San Diego State University, 2018

Professor Wayne Beach, Chair

The dissertation study focuses on care provider, parent, and child (5-11 years-old) discussions of diet, physical activity, and weight during well-child visits. The project utilized conversation analysis of 39 audio-recorded well-child visits (approximately 17 hours) in tangent with quantitative analysis of 39 post-visit parent-reported questionnaires.

Quantitative analysis explored possible variables related to parent-reported overall satisfaction with the medical visit, as well as parent-reported satisfaction with care provider

communication about weight, diet, and physical activity. Two-tailed Spearman's Rank Order Correlations revealed a strong, positive correlation between child age and parent-reported satisfaction with the care provider communication, *rho* (30)=.51 p=.004. Kruskal-Wallace tests revealed a statistically significant difference in parent-reported satisfaction with care provider communication across the three different visits with care provider groups, $\chi^2(2, n=33) = 8.83$, p=.012 as well as across the 5 categories of time with the care provider, $\chi^2(4, n=33) = 10.25$, p=.037. Parent satisfaction with care provider communication followed a u-shaped curve for both visits with the care provider and time with the care provider. These findings were used to inform and structure the qualitative analysis.

Qualitative analysis of the audio-recorded well-child visits were divided by child weight status. For *normal weight* patients, care providers applied weight-based labels (i.e., "slender guy"), excluded children from discussions, and neglected to fully address physical activity. For *overweight/obese* patients, care providers avoided weight-based labels, engaged in abstraction when discussing weight, and almost exclusively focused on encouraging changes in diet and physical activity. For *approaching/underweight* patients, care providers readily applied labels of thinness without adequately accounting for possible stigma; nutrition mostly treated as non-problematic; and physical activity discussions were minimal and not tailored to underweight status.

The results of the quantitative and qualitative analysis, taken together, elucidate several clinical recommendations for improving overall treatment of pediatric patients. These include avoiding stigmatizing weight-based labels and pejorative communication about diet and physical activity; considering a team-based strategy to fully address overweight/obese status; and more intentionally encouraging and tailoring physical activity for all weight groups.

Chapter 1: Literature Review and Methods

Literature Review

Importance of Well-Child Visits and Care Provider Communication about Weight

Well-child visits offer the ideal opportunity for care providers to evaluate and treat the overall health of the child and family from sleep to family functioning, to growth and development.[1] Well-child visits encompass an array of activities including a physical exam, screening tests (i.e., hearing), and assessment of growth.[1] As such, well-child visits provide a key occasion for care providers to ascertain if a child is normal weight, underweight, or overweight/obese for his or her age and gender; communicate the results to the parent and child; and provide treatment options.

The American Academy of Pediatrics (AAP) recommends that primary care providers annually assess *all* children for overweight/obesity risk. This includes a "shift" from only assessing patients who are obviously overweight or obese to "universal assessment, universal health messages, and early intervention".[2(pS169)] These guidelines emphasize that care providers should discuss diet and physical activity with children and family of *all* weights, encouraging and educating on specific healthy behaviors, even if weight does not appear to be an issue. Specifically, during every well-child visit, the AAP recommends that care providers identify the patient's weight status and risk by plotting BMI and also assessing child and parent history, diet, and physical activity.

For normal weight children, who do not have a family or behavioral risk, *prevention* is the focus of the well-child visit. The care provider should communicate to the patient and family the importance of specific health behaviors (e.g., limited screen time). Care providers should use motivational patient counseling techniques to promote these behaviors (e.g., motivational interviewing). For children who are overweight or obese, the AAP recommends a four-stage

treatment strategy. The first stage in the treatment plan mostly includes patient counseling. These stages are as follows: prevention plus, structured weight-management, comprehensive multi-disciplinary intervention, and tertiary care intervention. Each stage increases in effort and intensity as the patient’s health risk increases. Ultimately, the AAP frames the care provider as an essential resource in assessing *all* children’s overweight and obesity status.[2] This also includes providing prevention counseling for normal weight patients and offering treatment counseling for patients who are at risk.

As described above, care provider, patient, parent, communication is central to the AAP guidelines for assessment, prevention, and treatment of childhood overweight and obesity. Nonetheless, scarce research has examined these discussions.[3] Although care providers are often the “strategic first line of defense before BMI exceed recommended levels,”[3(p6)4] many care providers report feeling incompetent to discuss weight (in any capacity) with both adult and pediatric patients.[,] As a result, many cases of child overweight and obesity remain undiagnosed and therefore, untreated.[5] Additionally, because parents view care providers as medical authorities, some parents may not view their child’s weight as a problem without the care provider’s assessment.[6] As reviewed below, little research has explicated the role of care provider, patient, parent communication about weight, diet, or physical activity.

Previous Work: Pediatric Care Provider Communication about Weight

Previous work on care provider, parent, and child communication about weight has emphasized the need for sensitivity when informing parents about child overweight or obese status, so that parents and children do not feel defensive.[7,8] In fact, a major communication issue in the literature is ensuring that pediatric care provider communication about weight during assessment and treatment is not stigmatizing or pejorative. For example, a national study of US

parents with children 2-18 years old[8] sought to examine which terms for overweight and obesity parents preferred their care provider to use. The study discovered that parents preferred the terms "weight" and "unhealthy weight." Additionally, the terms "weight problem" and "unhealthy weight" were the most motivating for behavior change, and the terms, "fat," "extremely obese," and "obese" were seen as the least motivating and desirable, as well as indicating stigma and blame.

However, inoffensive communication during assessment and treatment of overweight and obesity is not the only consideration for pediatric discussions of weight. Previous research also highlights the need for pediatric discussions of weight to be motivating.[8,9] In fact, in a study that asked pediatric care providers what skill they thought would most help them successfully treat childhood overweight and obesity, pediatric care providers most frequently replied that learning skills to motivate patients would be the most helpful.[9]

A third theme in the literature on care provider, parent, child discussions of weight and weight management is the need for weight-related care provider communication to be culturally appropriate.[10,11] For example, one study[10] found that within an English-Speaking Latino parent population, there was no English term for overweight or obesity that was consistently motivating or inoffensive. However, for Spanish-speaking parents there was a phrase that was both inoffensive and motivating. Both English speaking and Spanish speaking Latino parents found it motivating and inoffensive when care providers linked discussions of weight with health risks.

Despite the rich work on pediatric care provider communication about weight, few studies have examined the actual, transcribed conversations about weight between care providers, parents, and children.

Conversation Analysis: Methodology and Theoretical Framework

Conversation analysis (CA) provides a unique set of analytic resources for exploring communication in pediatric encounters. CA is a rigorous, qualitative methodology that has been used to examine a wide array of ordinary conversations, institutional interactions, and diverse medical/therapeutic interviews.[12–14] Conversation analysts are most interested in *naturally occurring interaction.*[13] This entails video or audio recording communication as it is happening in its natural context, with interactions occurring whether or not recordings are being made.[15] The focus of CA is to study real time displays of communication behaviors, rather than asking participants to describe the communication after the fact via interviews, through pre-post measures, or by using surveys. Analysts prioritize the moment-by-moment methods used by speakers as they organize their communication to accomplish particular actions during the conversations (e.g., questions and answers during medical interviews). Researchers work with transcriptions and recordings to identify how speakers construct their communication and respond to each other's communication. From these descriptions, analysts can more broadly explain patterns of social conduct through these communication behaviors.

More than a rigorous methodology, CA is situated in a rich theoretical framework for explaining a wide array of social interactions. The following key terms may be helpful in understanding the proposed study and distinguishing this method from other forms of qualitative inquiry. CA examines how ordinary speakers co-produce conversations with particular actions like asking questions, making requests, or initiating a topic.[16] These are termed *key social actions*. For example, Beach and colleagues examined how patients made their fears available during oncology interviews, and in turn, how oncologists responded to patients' actions.[17] Attention was drawn to how patients displayed fear (directly and indirectly), and to physicians'

responses to these utterances and non-vocal actions (e.g., gaze and facial expressions). The researchers found that raising and responding to cancer fears occurred frequently during oncology and was consequential for care.

Additionally, because conversation analysts are interested in the underlying serial structure of communication, *sequence*s are critically important.[18] Sequences include how each speaker presents concerns, questions, or other types of conversational tactics and how the other speaker responds to these tactics, and in what order. For example, in the cancer fears project described above,[17] one instance is provided of how a patient solicits the oncologist for reassurance about her fears. When the physician next withholds reassurance, the patient continues to pursue reassurance until the physician closes the discussion by shifting topics and providing a biomedical explanation of her condition. These serial actions – seeking, withholding, pursuing, and shifting away from reassurance – reveal a sequence and pattern of action. The sequence and pattern of action from this example can be summarized as follows: patients raise concerns, and, in response, physicians often withhold addressing patient concerns– even when patients pursue those concerns. Indeed, across 70% of moments when patients raised concerns and emotional issues, physicians disattended psychosocial issues in favor of pursuing biomedical agendas.[12]

Gap: Conversation Analytic Research on Pediatric Discussions about Child Weight

The section below describes previous conversation analytic work in pediatrics as well as weight management. Notably, CA has never been applied in the context of care provider, parent, and child discussions of weight, diet, and physical activity. As such, there is an opportunity to apply conversation analysis in this new context.

Conversation analysis in pediatrics.

One researcher, Tanya Stivers, pioneered the use of CA in pediatrics (see: [19, 20]). In *Prescribing Under Pressure*,[20] Stivers closely examined care provider-parent-child communication about antibiotics. She gathered 882 video-recorded encounters with 54 care providers in 34 practices. Stivers identified communication strategies, used covertly and overtly by parents, when pressuring care providers to prescribe antibiotics for their children. Parents used these strategies during problem presentation, history-taking, diagnosis, and treatment phases of pediatric encounters, regardless of whether children actually needed these medications (e.g., when antibiotics are only effective for bacterial rather than viral conditions). As described by Stivers:

> Thus, although it may sound rather straightforward to say 'no antibiotics' for a viral upper respiratory tract infection, a close look at pediatric interactions…suggests that it is actually much more difficult to deny a sick child and the parents who simply want their child to feel better. So, at the root of a large-scale global health problem, as well as a classic social dilemma, is a micro-level problem in social interaction.[20](p185)

Stivers' work makes relevant the need for a similar analysis of weight, diet, and physical activity in pediatrics. Such an analysis would allow for further understanding of how the interaction between care provider, parent, and child might impact how weight, diet, and physical activity are addressed/or not addressed, as well as the competing agendas of parents, children, and care providers.

Conversation analysis and weight management for adults.

Previous research using CA has also examined care provider-patient discussions about weight in adult populations, but not in pediatrics.[21,22] One study found that when discussing weight in primary care, patients and care providers actively pursued conflicting agendas. For example, when discussing weight, patients prioritized their psychological concerns and personal

stories. Patients also framed weight-related discussions positively by emphasizing aspects like successfully losing weight and enjoying exercise. In contrast, when discussing the patient's weight, care providers emphasized biomedical agendas. Care providers also framed weight-related discussions negatively by emphasizing aspects like weight gain and the potential downsides of losing weight.[21] Additionally, primary care providers were apt to disregard patient's psychosocial concerns and personal stories. Although it is necessary for primary care providers to discuss weight biomedically in order to prevent and treat overweight, the researchers noted that care providers missed opportunities to encourage patients in their weight loss efforts. Similarly, pilot work applying CA to patient-care provider communication about weight management in oncology found that care providers tended to maintain rigid control of weight discussions, decided when and if discussions about weight management would be elaborated, and often dis-attended concerns patients raised about weight.[22]

Previous audio-recording research in pediatric discussion of weight.

Little prior work has examined actual communication between the care provider, parent, and child as a tool for assessing, preventing, and treating childhood overweight and obesity as well as encouraging healthy eating and exercise behaviors. To our knowledge only one recent study, by Turer and colleagues,[11] was identified that utilized video recordings involving pediatric care provider communication about weight. This study adopted a cross-sectional mixed-methods approach. Video-recorded pediatric well-child visits were used to examine communication between care providers and Latino parents and children with a particular focus given to care provider-parent language incongruence. The researchers defined language incongruence as "pediatrician limited Spanish proficiency combined with parent limited English proficiency".[11] [(p892)] Specifically, the researchers transcribed and coded video-recordings of well-child visits

with pediatric care providers, parents, and overweight Latino patients to examine if the communication adhered to the recommendations from the American Academy of Pediatrics (AAP). The AAP recommends that pediatric care providers: screen for overweight and obesity with all patients, conduct history taking and a medical examination to assess behavioral risk for overweight and obesity, and apply a staged treatment approach including both primary care weight management and referrals for further treatment. The researchers then coded the data using the AAP recommendations as their themes and sub themes. The researchers used bivariate analyses to determine if there were associations between adherence to the AAP guidelines and care provider--parent language incongruence. The researchers found that care providers were significantly less likely to use growth charts when the care provider had limited Spanish proficiency and the parent had limited English proficiency as compared to care providers and parents who were language congruent. In addition to coding for the AAP guidelines, the researchers also qualitatively examined *how* the care provider communicated that the child was overweight, how the care provider communicated weight management goals, and how the care provider discussed dietary recommendations. The researchers provided a brief discussion of these themes and subthemes in the results section of the paper.

Despite the findings of Turer and colleagues,[11] several avenues for future research in this area are apparent. First, Turer and colleagues examined only *one* direction of communication – care provider to parent/child – and did not examine how the parent and child contributed to this discussion. As discussed above, the researchers examined care provider communication as the behavior of interest not the interaction between the care provider, parent, and child. Because discussing weight can be potentially sensitive and offensive, it is important to understand how all speakers contribute to the discussion. Secondly, although Turer et al. utilized qualitative coding

in their analysis, they did not apply conversation analysis. As discussed above, CA has been used to examine a wide array of clinical settings.[23,24] CA is unique from other forms of qualitative inquiry because of its focus on social action, sequence, and its own set of theoretical constructs. This means that CA highlights how speakers use language to pursue their particular agendas (e.g., denying a request) and negotiate these agendas with others in interaction.

Previous research has not yet used CA to assess communication about weight, diet, and physical activity in pediatrics. This gap in knowledge is noteworthy because care providers report a lack of competency in discussing obesity with their adult patients.[25] This also includes a lack of perceived preparedness to counsel on most preventive issues.[26] Previous research has found many physicians in internal medicine under–diagnose child overweight and obesity.[5] Researchers posit one reason for this under diagnosis may be that doctors do not believe that discussing weight with their patients will be effective.[5]

Furthermore, Stivers' work on over-prescription of antibiotics in pediatrics[20] illustrates how conversation analysis of care provider and parent interaction may help elucidate how this very interaction is in fact the "root" of a public health issue. Such findings would not be possible without detailed, analytic work. Thus, an urgent need exists to closely examine naturally occurring interactions during routine pediatric encounters to elucidate how or if discussions about weight, diet, and physical activity contribute to public health.

Current Study

Study Design

This study is the first investigation to focus directly on how (or if) care provider, parent, and child visits involve discussions about weight, diet, and physical activity as well as linking these to parent-reported satisfaction with physician communication. The following study is

mixed methods—utilizing conversation analysis in unison with a quantitative post-visit questionnaire to assess care provider, parent, and child communication about weight, diet, and physical activity during 39 well child visits. Well-child visits provide an opportunity for pediatricians to discuss weight, diet, and physical activity with their patients.[1] Because of the importance of care provider communication about weight, diet, and physical activity for children of all weights, overweight/obese, normal weight, and underweight children were included in the study.

Research Questions

Several research questions guided both the qualitative and quantitative analysis. These are as follows:

Research question 1.

How do care providers, parents, and children discuss weight, diet, and physical activity in well-child visits? Because this is the first study to use conversation analysis to examine communication about weight in pediatrics, this first research question is intentionally exploratory. The goal is to move from the data outward, as is the practice in conversation analysis, and to pursue the lines of analysis that such an exploratory framework makes possible.

Research question 2.

In what ways are discussions about weight, diet, and physical activity similar or different between children of normal weight, overweight/obese, underweight status? To simplify and guide the conversation analysis, well-child visits were grouped according to child weight status (explained more fully in Chapter 3). This allowed for comparisons between groups and an assessment of how (or if) care providers, parents, and children discuss weight differently based on the child's weight status.

Research question 3.

How satisfied are parents with care provider communication about weight, diet, and physical activity, and what factors (if any) are related to satisfaction? The use of a quantitative post visit questionnaire allowed for an assessment of parent overall satisfaction with the well-child visit as well as satisfaction with communication about weight, diet, and physical activity, in particular. Such an analysis elucidated possible parent, child, or care-provider relationship factors related to satisfaction.

Taken together, these research questions highlight the exploratory focus on understanding care provider, parent, and child communication about weight in pediatric well-child visits.

Methods

Setting

Data were collected at one California pediatric clinic. The site was selected because it fit the study goals of a local pediatric clinic serving the general community. In fact, the clinic serves all members of the community, including children in foster care and with special needs. The clinic is also involved in the training and mentorship of medical students and residents. As such, care providers often worked in tangent with residents and students during well-child visits. This included involving the residents/students in various aspects of the well-child visit. Resident and student involvement ranged from conducting the majority of the well-child visit (as was the case for several residents) to accompanying the faculty care provider during the well-child visit, as was the case for several students. Faculty care providers were actively involved in mentoring and educating the residents and students in how to conduct the well-child visit and treat the parents and children.

The clinic setting was a pleasant environment with a comfortable waiting room complete with several rows of chairs, a fish tank, picture books, and cartoons playing on a mounted television. Parents checked in at the front of the sitting room with one of the clinic receptionists. Parents were then asked to wait in the waiting room for a medical assistant to call them. The exam rooms were colorful and bright and included an exam table, computer, and chairs.

Data collection began on February 26th 2016 and was completed on June 15th 2016. During the course of data collection, the researcher visited the clinic site ***32*** times for approximately ***180.5*** hours. The study was approved by the University of California San Diego Institutional Review Board.

Participants

Study participants were a purposive sample of pediatric care providers, parents, and children. All care providers completed written informed consent as well as written audio consent. All parents completed written informed consent, written audio consent, and written parental permission for their children. Additionally, all children 7-18 years completed verbal child assent, in addition to written parental permission. For children 6 years old and younger, written parental permission was deemed sufficient.

Care providers.

Care providers were included in the study if they were medical faculty, medical residents, trainees, and medical assistants working at the study clinic who completed informed consent, were over 21 years old, and could read and speak in English.

Parents and children.

Parents were included in the study if they completed informed consent, were over 21 years old, could read and speak in English; were able to understand the study rationale, did not

possess any conditions that could impede study compliance, and had a child between the ages of 5-11 who fit the study criteria and was scheduled for a well child visit with one of the study care providers.

Children were included in the study if they were 5-11 years old, completed verbal assent (for those over 7 years old), had a parent who completed written informed consent as well as signed parental permission, were scheduled for a well-child visit with one of the study care providers, could speak in English, and, did not possess any conditions that could impede study compliance. Children of all weight categories were included in the study with the goal of capturing diverse conversations about weight, diet, and physical activity including prevention and control.

Recruitment

Clinic.

The study clinic was recruited through a local contact in charge of a pediatric clinic. The contact agreed to be a part of the study and invited the research team to meet the clinic faculty. After the meeting, the clinic faculty agreed to host the study, and a clinic lead was assigned. The research team performed ethnographic shadowing at the clinic for one day. This involved following the clinic lead throughout the day to witness the specifics of the clinic process, build clinic relationships, and become familiar with the setting. Based on these observations, the research plan was modified to reflect the unique aspects of the study site.

On February 26th 2016, the research team attended a meeting with clinic faculty followed by a second meeting with clinic staff. During these meetings, the research team presented the research plan to the faculty pediatricians and completed informed consent with any who agreed to participate. At the faculty meeting, four faculty care providers agreed to participate.

Additionally, two additional faculty care providers were recruited, who were not at the faculty meeting. Next, the clinic staff were recruited, and informed consent was completed with any who agreed to participate. Five of the six medical assistants agreed to participate.

In general, both the faculty care providers and the staff were receptive to consenting requests. Notably, several of the care providers at the faculty meeting did not consent to be a part of the research. However, the research was framed as voluntary and any who wished to participate were given the opportunity, and those who did not wish to participate were not pressured to participate. This initial recruitment allowed study commencement. However, care provider recruitment and informed consent continued throughout the duration of the study. As mentioned previously, two of the faculty pediatricians who were not at the faculty meeting, agreed to be a part of the study. Additionally, students/residents who were involved in the well-child visits were recruited on a daily and weekly basis.

Parents and children.

The clinic staff provided appointment times of potentially eligible participants (although not the names or full birth dates). When potentially eligible parents/children arrived, the research team greeted them and asked them if they would like to be a part of the study. If they agreed, they completed a brief screener, to fully determine eligibility, and then proceeded with written parent consent, written parental audio consent, written parent permission for the child, and child verbal assent.

Measures

The current study includes both qualitative and quantitative analysis. These qualitative and quantitative measures, are discussed below.

Qualitative measures.

The 39 well child visits, comprising approximately 17 hours of audio recording were de-identified and digitized, with participant names and identifying information removed. The recordings were professionally transcribed. The analysis process included: a) listening to all recording and b) analyzing the written transcriptions using the method of Conversation Analysis, detailed above.

Quantitative measures.

The quantitative measures included both a pre-visit care provider questionnaire and a post-visit parent questionnaire. Measures were informed by previous research.[11,27–31]

Care providers completed a brief, printed questionnaire to assess: a) demographics, b) job title, and c) self-rated communication skills. To assess care provider demographics the questionnaire included care provider ethnicity, race, age, gender, and self-reported height/ weight. To assess job title the questionnaire asked for job education/title. Response options were: a) Trainee, b) Resident, c) Faculty, d) Nurse, and e) Administrator. The questionnaire also asked care providers to rate their own general communication skills. Response options included: a) Very good, b) Good, c) Somewhat good, d) Neither good nor poor, e) Somewhat Poor, f) Poor, g) Very Poor.

After the well-child visit, the parent completed a questionnaire to assess the following: a) child demographics, b) parent demographics, c) household demographics, d) parent relationship with the care provider, e) parent overall satisfaction with the well-child visit, f) if the care provider discussed weight, and g) parent satisfaction with the care provider's discussion of weight, diet, and physical activity.

To measure child demographics, the questionnaire included child ethnicity, race, age, gender, height, and weight. Because the research team did not have access to clinic information, like the child's height and weight, this information was gathered using parent self-report. Child age, gender, height, and weight, were used to calculate the child's BMI.

To assess parent demographics the questionnaire included: parent ethnicity, race, age, and gender. To measure household characteristics, monthly household income was included.

To assess the parent relationship with the care provider, the questionnaire included: parent-reported length of time with care provider (ranging from first visit to 5 or more years), number of previous visits (ranging from first time visit to 6 or more visits), and if the care provider is seeing any other children in the family.

The questionnaire asked parents to rate their overall satisfaction with the well-child visit with 5 response options ranging from "Very satisfied" to "Very dissatisfied". The questionnaire also assessed *if* the care provider discussed weight, diet, and physical activity with the parent and child. Response options included "Yes" or "No." If the answer was yes, parents were directed to fill out a subsequent scale.

To assess parent satisfaction with care provider communication about weight, diet, and physical activity, communication subscales of the Parent's Medical Interview Satisfaction Scale (P-MISS) were used,[28] modified to discussions of weight, diet, and physical activity. The Medical Interview Satisfaction Scale (MISS) [29] measures patients' evaluation of their medical encounters. Although created in 1978, the MISS is one of the 'gold standards' of medical interview assessment. It has been adapted to different contexts including health specific contexts like breast cancer.[32] The MISS was specifically adapted to pediatric interviews in a validated P-MISS scale.[28] Using factor analysis, the researchers found four main factors present in the scale:

physician communication with child, physician communication with parent, relief of distress, and adherence intent.[28] The researchers then tested the modified scale on a field trial with a sample of 50 parents. The P-MISS had high alpha reliability (Cronbach's alpha=.95).

Given that the majority of items (17 out of 27) focus on physician communication, the P-MISS scale is an ideal scale for the present project. The present study used two subscales of the P-MISS, *physician communication with child* (Cronbach's alpha=.93) and *physician communication with parent* (Cronbach's alpha=.81). As mentioned above, the measure was also modified from a *general* measure of pediatric care provider communication to a measure of pediatric care provider communication *about weight*, *diet, and physical activity*. The modifications entail simply adding the phrase "about weight, diet, and physical activity," to the end of most of the items. For example, "the care provider listened carefully to what I said about my child's weight, diet, and physical activity." The P-MISS scale was modified because a general measure of parent-reported satisfaction with care provider communication may have inadvertently measured other positive care provider communication behaviors that were not related to weight- related discussions. The measure was also tailored so that the parent would reply in first person rather than third person.

The resultant 17-item measure assesses parent-reported satisfaction with care provider communication about weight, diet, and physical activity (see Appendix). Responses are measured on a 7-point Likert scale ranging from "Strongly Agree" to "Strongly Disagree." Questions include both negatively worded items like: "The care provider did not really give me a chance to speak about my child's weight, diet, and physical activity"; and positively worded items like: "The care provider explained weight, diet, and physical activity very well to my child." Negative items were reverse-coded before analysis. The modified scale is titled: *Parent*

Medical Interview Satisfaction Scale with Communication about Weight, Diet, and Physical Activity, or P-MISS-CWDPA. Reliability results of the P-MISS-CWDPA are presented in Chapter 2.

Procedures

Audio recording well-child visit and parent questionnaire.

After completing the parent and child's informed consent, the audio-recorder was set up in the exam room. The research team would then exit the room until the care provider arrived. At the care provider's arrival, the research team would enter the room, turn on the recorder, and leave until the end of the visit. At the end of the visit, the audio recorder would be turned off and the parent would be provided with a written questionnaire.

Data Analysis

Qualitative Analysis

The qualitative research analysis uses conversation analysis. Specifically, this includes: 1) listening to the 39 recorded well-child visits, which included approximately 17 hours of audio-recordings; 2) reading and analyzing the transcriptions. The subsequent analysis was guided as follows by research questions one and two.

Research question 1.

Research question one states: "*How do care providers, parents, and children discuss weight, diet, and physical activity in well-child visits?* Pursuit of this research question included: 1) listening to the recordings; 2) reading and studying the transcriptions; 3) tracking themes to identify conversational patterns (i.e., care providers using weight-based labels); 4) grouping themes into collections and organizing by weight-status; 5) applying conversation analysis to examine these collections line-by-line.

Research question 2.

To organize the conversation analysis, well-child visits were grouped according to child weight status. This organization was guided by research question two: *In what ways are discussions similar or different between children of normal weight, overweight/obese, or underweight?* As mentioned earlier, data were grouped both according to themes and according to child weight status. This provided for comparisons between groups and an analysis of how (or if) care providers, parents, and children discuss weight differently based on the child's weight status. In fact, the conversation analysis results are organized by weight status. Specifically, Chapter 3 examines normal weight patients; Chapter 4 explicates approaching/overweight/obese patients, and Chapter 5 focuses on approaching/underweight patients.

Quantitative Analysis

Research question 3.

The quantitative analysis focuses on research question 3: *How satisfied are parents with care provider communication about weight, diet, and physical activity, and what factors (if any) are related to satisfaction?* The use of a quantitative post visit questionnaire allows for an assessment of parent overall satisfaction with the well-child visit as well as satisfaction with weight, diet, and physical activity, in particular. It also allows for an analysis of what parent and child demographic factors or care provider factors might be related to this satisfaction. A full description of the analysis process, procedures, and findings are presented in Chapter 2.

Chapter 2: Quantitative Analysis/Results and Qualitative Framework

The following chapter presents two main components: a) quantitative analysis and results, and b) resultant qualitative framework and preview. As mentioned in Chapter 1, the data includes 39 audio-recorded well-child visits (approximately 17 hours of recordings), 39 parent post-visit questionnaires, and 24 pre-visit care provider questionnaires.

Quantitative Analysis and Results

The following quantitative analysis uses *IBM SPSS statistics* version 24. The quantitative analysis results include a description of the sample and analysis of scale reliability, outcome variables, and results.

Description of the Sample

The following section outlines care provider, parent, and child descriptive statistics as well as household characteristics and relationships to the care provider.

Care provider descriptive statistics.

Table 1 (below) presents the care provider descriptive statistics as reported by the care providers in the pre-visit questionnaire. Medians and interquartile range (*IQR*) are reported for the continuous variables, as is recommended for variables that do not appear normally distributed.[33]

Table 1: Care Provider Descriptive Statistics (n=24)

Continuous Variables	n	Md (IQR)
BMI	24	24.1 (22.5, 25.3)
Age	22	29.5 (26, 40)
Categorical Variables	**Frequency**	**Percent**
Gender		
Female	14	58.3%
Latino Ethnicity		
Yes	5	20.8%
Race		
Asian	5	20.8%
African American	1	4.2%
Native American/Alaskan	1	4.2%
White	14	58.3%
Other	3	12.5%
Job Title		
Nurse/Medical Assistant	3	13.0%
Trainee	8	34.8%
Resident	6	26.1%
Faculty	6	26.1%
Communication Skill		
Neither good nor poor	2	8.3%
Somewhat good	2	8.3%
Good	13	54.2%
Very Good	7	29.2%

The median age of the care providers was quite young (*Md*=29.5 years). This young age might be explained by the fact that the study clinic was a training clinic and, thus, the care provider sample included trainees, residents, and medical assistants, as well as faculty care providers. The median BMI for care providers was 24.1. Given that the Centers for Disease Control and Prevention[34] describes a healthy adult BMI as between 18.5 and 24.9, the care provider median BMI of 24.1 is within the healthy range, although on the higher end of this range.

The percent of female to male care providers was fairly balanced with 58.3% female. Over a fifth of the care providers (20.8%) identified as Latino ethnicity. Over half of the care

providers were white (58.3%), followed by 20.8% Asian, 4.2% African American, 4.2% Native American or Alaskan Native, and 12.5% other. The job titles of the care providers were fairly balanced between trainee (34.8%), resident (26.1%), and faculty (26.1%), with fewer nurses/medical assistants at 13.0%.

The majority of care providers rated their communication skills as "good" (54.2%), with 29.2% reporting "very good," 8.3% "somewhat good," 8.3% "neither good nor poor." Notably, none of the care providers rated their own communication as "somewhat poor," "poor," or "very poor." The care providers' high self-reported communication skills indicate that the majority of care providers viewed their communication skills as fairly proficient.

Child descriptive statistics.

Table 2 (below) describes the child demographics as reported by the parent in the post-visit questionnaire. For continuous variables, the distribution was examined for normality. Medians and interquartile range (*IQR*) are reported for continuous variables that are not normally distributed.[33] Mean and standard deviations are reported for continuous variables that are normally distributed.

Table 2: Child Demographics (n=39)

Continuous Variables	**n**	**Mean (SD)/Median(IQR)**
Age	36	9 (6, 9.8)
BMI percentile	33	47.5 (28.3)
Categorical Variables	**Frequency**	**Percent**
Gender		
Male	23	59%
Female	16	41%
Latino Ethnicity		
Yes	9	23.1%
Race		
White	29	74.4%
Asian American	5	12.8%
Other	1	2.6%
Marked more than 1 race	4	10.3%

The median child age was 9 years old—on the higher end of the 5-11-year-old targeted age range. The mean BMI percentile, which was determined based on the parent's report of the child's height, weight, age, and gender, was 47.5. As described by the Centers for Disease Control and Prevention, a child's BMI can be expressed as a percentile.[35] The 5th percentile to less than the 85th percentile is considered a healthy or normal BMI.[35] Given the mean BMI percentile for children in the sample was the 47.5th percentile, the sample, as a whole, was a fairly healthy weight. Notably, when parents were asked to report their child's height and weight on the post-visit questionnaire, several parents decided to either not do so, or did so with incomplete or erroneous information. As a result, BMI information was missing for 6 of the 39 child participants. For the purpose of the quantitative analysis, missing BMI information was coded as missing. However, a full count of child weight status is provided below using both the parent-reported questionnaire (when this information was available), as well as information from the well-child visit for the cases when parents did not provide information in the questionnaire. This count is as follows: underweight/approaching underweight (n=5), normal weight (n=27), approaching overweight/overweight/obese (n=6), missing/unclear (n=1). The "approaching" categories are defined and explained in each chapter.

Child gender was fairly balanced with 59% males and 41% females. Almost a quarter of the children (23.1%) were Latino. As described in the methods section (see Chapter 1), ethnicity and race were asked as separate questions on the parent-reported questionnaire, so parents who marked "yes" for their child's Latino ethnicity were also asked to report an additional racial category. The majority of children were white (74%) with a number of Asian children as well (12.8%).

Parent and household descriptive statistics.

Table 3 (below) describes the parent demographics as reported by the parent in the post-visit questionnaire (see Chapter 1 for more details). Mean and standard deviations are reported.

Table 3: Parent Demographics (n=34)

Continuous Variables	**n**	**Mean (SD)**
Age	32	41 (8.2)
Categorical Variables	**Frequency**	**Percent**
Gender		
Male	5	14.7%
Female	29	85.3%
Latino Ethnicity		
Yes	4	11.8%
No	30	88.2%
Race		
White	26	76.5%
Asian American	5	14.7%
Don't know	1	2.9%
Did not mark any race	1	2.9%

As seen in Table 3, the mean parent age was 41 years old (*SD*=8.2). Additionally, 11.8% of parents were Latino. As described in the methods section (see Chapter 1), ethnicity and race were asked as separate questions on the parent-reported questionnaire, so parents who marked "yes" for Latino ethnicity were also asked to report an additional racial category. The majority of parents were white (76.5%) and female (85.3%), with a number of Asian parents as well (14.7%). Please note that the total number of parents (n=34) is less than the total number of child participants (n=39). This is because several parents had more than one child included in the study. These parents filled out a questionnaire for each child. However, the parent demographic information was reduced so that only one set of demographic information for each parent was reported.

Table 4 describes the household characteristics (i.e., income) as reported by the parent in the post-visit questionnaire.

Table 4: Household Characteristics/Income (n=39)

Categorical Variables	**Frequency**	**Percent**
Monthly Household Income		
$5,000 or less	5	13.2%
$5,001 or more	33	86.8%

Notably, parents reported a high income with only 13.2% reporting monthly household income categories of $5,000 or less, and the majority (86.8%) reporting a monthly household income of $5,001 or more. Further discussion of the potential impact of such a high-income sample, will be further discussed in the final chapter.

Relationship with the care provider.

Table 5 (below) presents the relationship with the care provider as reported by the parent in the post-visit questionnaire.

Table 5: Relationship with Care Provider

Time with Care Provider	**Frequency**	**Percent**
First Visit	5	12.8%
1-6 Months	3	7.7%
7-12 Months	4	10.3%
2-4 Years	7	17.9%
5 or More Years	20	51.3%
Visits with Care Provider		
First Visit	5	12.8%
2-5 Visits	10	25.6%
6 or More Visits	24	61.5%
Siblings with CP		
Yes	27	71.1%
No	4	10.5%
Not Applicable	7	18.4%

As depicted in Table 5, the majority of parents reported that they had been seeing their care provider for 5 or more years (51.3%). Additionally, the majority of parents also reported that they had had 6 or more visits with the care provider (61.5%), and that they had additional children seeing that care provider (71.1%).

Analysis of Scale Reliability, Outcome Variables, and Results

Data analysis focused on the outcome variables of parent-reported satisfaction with care provider communication about weight, diet, and physical activity (as measured by the P-MISS-CWDPA scale) and parent-reported overall medical interview satisfaction, which was measured by asking parents to rate their satisfaction with the appointment. Child demographics, income, and relationship with the care provider were tested against these aforementioned outcome variables. Before examining these outcome variables, however, it is important to discuss the reliability of the modified Parent Medical Interview Satisfaction Scale with Communication about Weight, Diet, and Physical Activity (P-MISS-CWDPA).

Reliability results of P-MISS-CWDPA.

The 17-item *Parent Medical Interview Satisfaction Scale with Communication about Weight, Diet, and Physical Activity*, P-MISS-CWDPA, was found to have high internal consistency with a Cronbach alpha coefficient of .94. This indicates that the P-MISS-CWDPA scale, modified to specifically examine communication about weight, diet, and physical activity, exceeds the minimum .7 level espoused by previous research,[36] and has high reliability.

The median and Inter-Quartile Range for the individual items of the P-MISS-CWDPA scale are presented below. All scale items were negatively skewed, with most participants reporting high scores on the scale items. Furthermore, all items tested significant on the Kolmogorov-Smirnov test of normality indicating that a normal distribution cannot be assumed.[33] Therefore, the median and Inter-Quartile Range are presented in the table below. Reverse coded items are marked with an asterisk.

Table 6: Scale Results: Parent Medical Interview Satisfaction Scale with Communication about Weight, Diet, and Physical Activity (P-MISS-CWDPA) n=39

Scale Item	n	Median (IQR)
The care provider listened carefully to what I said about my child's weight, diet, and physical activity	36	7 (7, 7)
The care provider did not really give me a chance to speak about my child's weight, diet, and physical activity*	36	7 (6.5, 7)
I felt understood by the care provider when discussing my child's weight, diet, and physical activity	36	7 (7, 7)
The care provider did not appear to understand my reason for discussing my child's weight, diet, and physical activity*	36	7 (7, 7)
The care provider gave a poor explanation of my child's weight and/or diet, and physical activity*	36	7 (7, 7)
The care provider seemed to have other things on his/her mind*	36	7 (7, 7)
The care provider talked to my child about what (s)he can do to eat healthfully and/or exercise	36	6 (4.5, 7)
The care provider seemed to think it was important for my child to understand, weight, diet, and physical activity	35	7 (6, 7)
The care provider encouraged my child to talk about weight, diet, and physical activity	35	7 (6, 7)
The care provider listened closely to my child talk about weight, diet, and physical activity	35	7 (6, 7)
The care provider knows how to talk to children about weight, diet, and physical activity	35	7 (6, 7)
The care provider used words too difficult for the child to understand when discussing weight, diet, or physical activity*	35	7 (7, 7)
The care provider really understood how the child feels about weight, diet, and physical activity	35	7 (6, 7)
The care provider explained weight, diet, and physical activity very well to my child	35	7 (5, 7)
The care provider excluded my child from most of the discussions of weight, diet, and physical activity*	35	7 (6, 7)
My child could not understand most of what the care provider said about weight, diet, and physical activity*	34	7 (6, 7)
The care provider seemed to think about my child's weight, diet, and physical activity carefully	35	7 (6, 7)

Responses were measured on a Likert-type scale from 7 (strongly agree) to 1 (strongly disagree). Seven items were negatively worded and reverse coded for analysis. The high median score for all items on the scale (all but one item had a *Md*= 7) indicates high satisfaction with care provider communication about weight, diet, and physical activity. A histogram was examined to assess the shape of the P-MISS-CWDPA scale's total distribution. Based on the non-normal, negatively skewed distribution of the P-MISS-CWDPA scale, non-parametric tests were used for further analysis.

Results for outcome variables.

Overall, 89.7% of parents reported that the care provider discussed diet, physical activity, or weight with them. Conversely, 7.7% of parents replied that the care provider did not discuss diet, physical activity, or weight with them; and 2.6% did not answer this question. If parents replied yes to this question, they were asked to fill out the 17-item P-MISS-CWDPA scale measuring care provider communication about weight, diet, and physical activity (discussed in-depth in the above section).

As mentioned in the scale reliability section, there were high median scores for all items on the P-MISS-CWDPA scale with 16 of the 17 items garnering a median score of 7 out of 7. This indicates a high overall satisfaction with care provider communication about weight, diet, and physical activity.

Overall, parents reported being highly satisfied with their child's medical visit, with the median score being the highest possible response value (M*d*=5, *IQR*: 5,5). In fact, parents only reported being "Very satisfied" or "Satisfied" with their medical visit. None of the parents reported being "Neither satisfied nor dissatisfied," "Dissatisfied," or "Very dissatisfied." The results of the outcome variables indicate that, overall, parents had a positive experience with care

provider communication about weight, diet, and physical activity, as well as with their overall medical visit.

Selected child demographic variables, household characteristics, and outcome variables.

A series of Spearman's Rank Order Correlations and Mann-Whitney U-tests were used to assess the relationship between selected child demographic variables and the outcome variables of parent-reported care provider communication (as measured by the P-MISS-CWDPA scale) as well as parent-reported overall medical interview satisfaction.

To assess the relationship between select continuous child demographic variables (i.e., child age and child BMI percentile) and parent satisfaction with care provider communication about weight, diet, and physical activity (as measured by the P-MISS-CWDPA), a series of bivariate Spearman Rank Order Correlations were used. Bivariate Spearman Rank Order Correlations were also used to assess the relationship between these same select continuous child and household demographic variables and parental satisfaction with the medical interview. Spearman Rank Order Correlations were used because preliminary analyses indicated that the outcome variables violated the assumptions of normality

A 2-tailed test revealed a strong, positive correlation between child age and parent-reported satisfaction with care provider communication about weight, diet, and physical activity (as measured by the P-MISS-CWDPA), *rho* (30)=.51 p=.004, with higher child age associated with higher parent-reported satisfaction with care provider communication about weight, diet, and physical activity.

A series of Mann-Whitney U tests were used to assess selected categorical child demographic variables (i.e., child ethnicity, race, gender) against parent-reported satisfaction

with care provider communication about weight, diet, and physical activity (as measured by the P-MISS-CWDPA) as well as overall satisfaction with the medical appointment. The Mann-Whitney tests revealed no statistically significant differences between groups at the $p<.05$ significance level.

Relationship with the care provider and outcome variables.

A series of Kruskal-Wallis tests were used to examine parent-reported relationship with the care provider against the aforementioned outcome variables. Parent relationship with the care provider included: time with the care provider and visits with the care provider. Time with the care provider included first time visit, 1-6 months, 7 months to 1 year, 2-4 years, and 5 or more years. Visits with the care provider included first visit, 2-5 visits, 6 or more visits.

A Kruskal-Wallace test revealed a statistically significant difference in parent satisfaction with care provider communication about weight, diet, and physical activity (as measured by the P-MISS-CWDPA scale) across the three different visits with care provider groups, $\chi^2(2, n=33) =8.83$, $p=.012$. Table 7 (below) provides the mean rank for parent satisfaction with care provider communication for each visit group. Parents attending a first visit with the provider reported the highest mean rank satisfaction (26.4). Parents who reported this was their 2-5 visit had the lowest satisfaction (10.2) and parents who reported 6 or more visits had a middle satisfaction score (18.2).

A Kruskal-Wallace test also revealed a significant difference in parent satisfaction with care provider communication about weight, diet, and physical activity (as measured by the P-MISS-CWDPA scale) across the 5 categories of time with the care provider, $\chi^2(4, n=33) =10.25$, $p=.037$. This indicates that the distribution of parent-reported satisfaction with care provider communication about weight, diet, and physical activity (as measured by the P-MISS-CWDPA)

was significantly different across visits with the care provider. Table 7 (below) outlines the mean rank scores for parent satisfaction with care provider communication for each category of time. As was the case with number of visits (see above), parents attending a first visit with the care

Table 7: Parent Satisfaction with Care Provider Communication by Relationship with Care Provider

Number of Visits with Care Provider	**Mean Rank**	**n**
First Visit	26.4	4
2-5 Visits	10.2	9
6 or More Visits	18.2	20
Total N		33
Time with Care Provider		
First visit	28.0	4
1-6 Months	14.3	2
7-12 Months	9.4	4
2-4 Years	12.4	7
5 or More Years	18.5	16
Total N		33

provider also reported the highest satisfaction score (28.0). Parents who had been with the provider for 7-12 months had the lowest satisfaction score (18.5).

As seen in the table above, and depicted in the figures below, parent-reported mean rank of satisfaction with care provider communication followed a u-shaped pattern for both number of visits and length of time with the care provider. Figure 1 depicts the mean rank of parent satisfaction with care provider communication by number of visits. As depicted, the figure shows a clear u-shaped pattern.

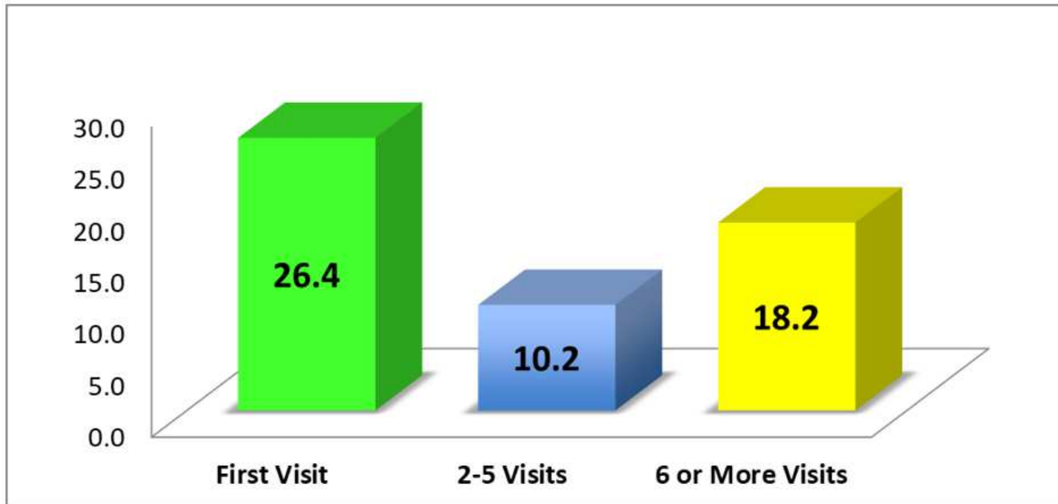

Figure 1: Mean rank of parent satisfaction with care provider communication by visit.

Figure 2 (below) depicts the mean rank of parent satisfaction with care provider communication by time with the care provider. As depicted, the u-shaped pattern is quite apparent, with the middle number of visits having the lowest satisfaction scores.

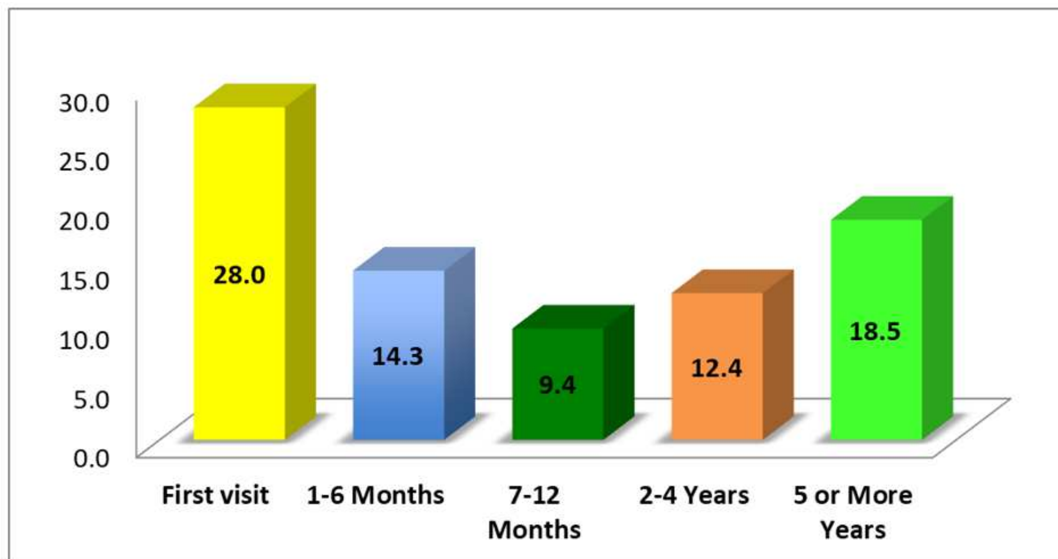

Figure 2: Mean rank of care provider satisfaction by time with care provider.

This indicates that parents were most satisfied with the care provider communication about diet, physical activity, and weight if they were new with the care provider or had been with

the care provider for a longer time. The parents who were in the middle time/visit range had the lower communication satisfaction scores. A full discussion of this finding will be provided below.

Similarly, a Kruskal-Wallace test revealed a statistically significant difference in parent overall satisfaction with the medical visit across the three different visits with care provider groups, $\chi^2(2, n=38) = 8.88$, $p=.012$. The mean rank score also followed a u-shaped pattern (similar to the findings above). Specifically, parents who reported this was their first visit had high satisfaction (21.0); parents who reported his was their 2-5 visit had the lowest satisfaction (15.3); and parents who reported 6 or more visits had the same high satisfaction score as parents reporting a first time visit (21.0). Lastly, a Kruskal-Wallace test also revealed that there was no statistically significant difference in parent overall satisfaction with the medical visit across the five categories of time with the care provider at the $p<.05$ significance level.

Discussion of Key Results and Inclusion into CA Analysis

Parent satisfaction with care provider communication about weight, diet, and physical activity is positively related to child age, with higher age related to higher communication satisfaction. This may be because parents with older children may encounter more child engagement and a richer resultant discussion. The following conversation analysis will include an examination of care provider inclusion of the child and note child ages throughout the analysis (see Figure 3 below).

Parent satisfaction with care provider communication about weight, diet, and physical activity follows a u-shaped pattern across both time with the care provider and visits with the care provider. These findings, taken together, provide a powerful case for the importance of care provider and parent relationship to parent satisfaction with care provider communication.

Examining the in-context communication during well-child visits could help elucidate why communication satisfaction might be highest for 1st time and long-time parents of pediatric patients.

Resultant CA Framework and Integration of Qualitative and Quantitative Analysis

As discussed in Chapter 1, the current mixed-methods project integrates both quantitative and qualitative methods. In order to best integrate these methods, the qualitative conversation analysis framework is informed by and includes the findings from the above quantitative analysis in several key ways:

As mentioned, child age will be included when discussing each conversation analysis transcription excerpt to incorporate the finding that these variables may be involved in parent reported satisfaction with care provider discussion of diet, physical activity, and weight. Also, each qualitative chapter will include a section discussing how the findings relate to, explain, and are explained by the quantitative findings, with the hope that the qualitative and quantitative portions of the project will work together to provide a fuller picture of communication in pediatrics.

The figure below visually depicts and previews the conversation analysis framework used to guide remainder of the project. The findings presented in the figure below will be fully discussed in each subsequent chapter.

Conversation Analysis Framework: A Conclusion and an Introduction

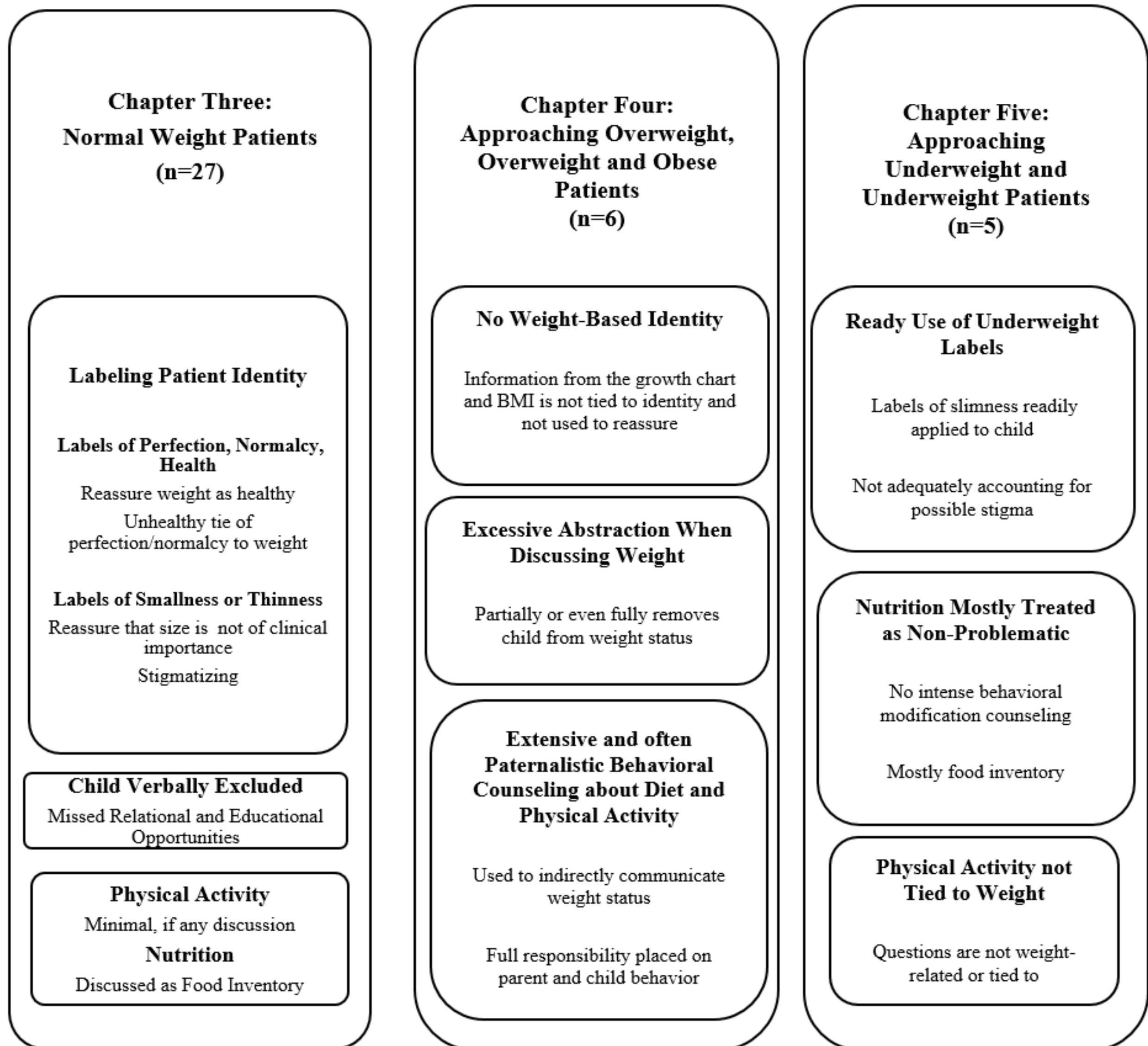

Figure 3: Key Findings for all weight categories.

Chapter 3: Well-Child Visits with Normal Weight Children

The majority of well-child visits included normal weight children who are not at immediate risk for being underweight or overweight. Given that the Academy of Pediatrics recommends that pediatricians focus on prevention and education as well as diagnosis and treatment,[2] close examinations of these visits provides a crucial opportunity to analyze 'benchmark' interactions between care providers, parents, and children when discussing diet, physical activity, and weight.

Several key patterns are identified that comprise the majority of these well-child visit interactions involving normal weight patients and their parents. First, care providers label the patients' identities based on findings of the growth chart and BMI. Second, care providers verbally exclude children in discussions of BMI, growth charts, and weight – directing these discussions almost exclusively to parents, and thus missing crucial relational and educational opportunities with children as patients. Third, care providers and parents only minimally discuss physical activity by asking one or two questions, and often neglect to ask even a single question about physical activity. In contrast, nutrition is discussed in almost every well-child visit, usually in the form of a thorough food inventory, indicating that physical activity might not be given the same priority as nutrition in well-child visits.

These key findings are summarized in Figure 4 (below). Each of the major findings are then examined in more detail as this chapter unfolds.

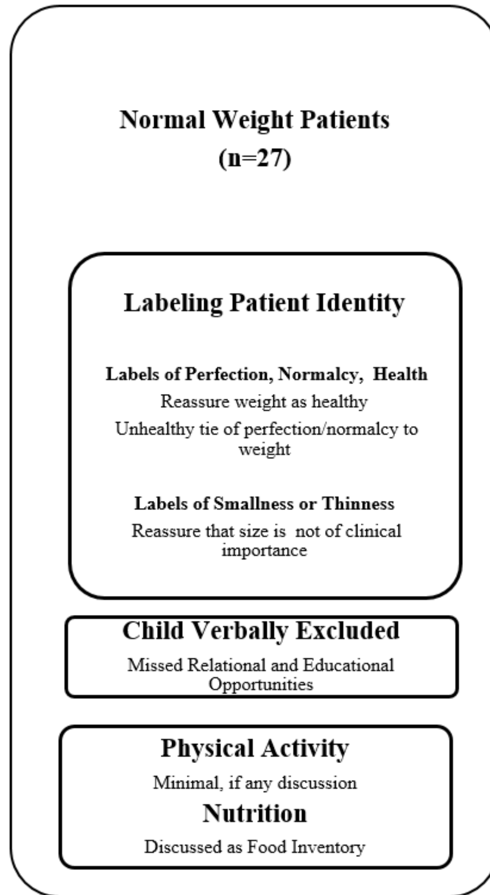

Figure 4: Key findings for normal weight patients (n=27).

Labeling the Patient's Identity Based on the Growth Chart and BMI

In the majority of well-child visits with normal weight patients, care providers moved from presenting the information of the growth chart and BMI to labeling the child's identity based on the weight-information (i.e., "You're perfect"). Previous research[37] has indicated that the application of identity labels based on weight (i.e., thin) have a powerful normalization effect, directly impacting what is viewed as a normal or acceptable weight. Thus, care providers' use of labels when discussing weight with children and parents has the potential to directly impact children's views of their own bodies.

Table 8 outlines the weight-based labels used by care providers while reviewing the growth chart and BMI with normal weight patients. Weight-based identity labels are here

delineated as particular statements used to define a whole person based on a specific weight status (i.e., "She's a smaller girl"). In particular, these labels extend beyond merely relaying weight and growth information, and instead are used to define who a person *is* in his or her entirety—not just his or her weight results. These labels mostly cluster into two types of labels. The first type of labels were labels of perfection and health. For example, this included labels

Table 8: Identity Labels used by Care Providers with Normal Weight Patients

Labels of perfection and health	**Labels referencing smallness and thinness**
• "He's **totally normal** and **healthy**" • "**Healthy girl**" • "She's very **healthy** and **normal**" • "She's pretty much **perfectly proportional**" • "**healthy**" • "you're **perfect**" • "**healthy girl**" • "he is a **completely normal average healthy guy**"	• "They're both on th**e petite** end, but **very symmetric**" • "On the **smaller side**" and "he's a **little skinnier**" • "He's on the **smaller side** as well" • "She's a **smaller girl**" • "**skinnier**"

like, "you're perfect," "totally normal and healthy," and "healthy girl." The second type were labels referencing the child's smallness and thinness. For example, this included labels like "On the smaller side," "he's a little skinnier," and "She's a smaller girl".

Social Actions Comprising Labelings of Perfection, Normalcy, and Health

As outlined in Table 8, after reviewing the growth chart and BMI, care providers invoke labels indicating perfection, normalcy, and health. A series of examples are closely examined below that reveal how labeling gets done as a social accomplishment involving parents and care providers.

"Perfect".

One example of care providers using this type of labeling occurs in a well-child visit with a nine-year old-girl and her mother. Earlier in the visit, the care provider has informed the mother and daughter of where the daughter "falls" on the growth chart. The care provider has also explained and educated the parent and child about the growth chart.

Please note that transcription excerpts are labeled using the following notation (e.g., Pediatrics 24.5). The term 'Pediatrics' is used because the well-child visits occurred in a pediatric clinic. The first number, (e.g., '24') indicates the well-child visit, and the second number (e.g., '5') indicates the transcription page number. Additionally, for the sake of simplicity, the transcription excerpts included throughout the manuscript do not include conversation analysis transcription symbols, which are used to depict additional aspects of the interaction, like pitch, volume, or pauses (see: [38]). Rather the transcriptions included in the present manuscript utilize a basic transcription format without the use of such symbols.

1) Pediatrics 24.5

1	Care Provider:		And how tall dad is. So, that puts you right – that should pull you right in that
2			direction.
3	Mom:		So, she's she's she's okay. Right? She's just-
4	Care Provider:	→	**Perfect.**
5	Mom:		**Perfect**. Okay.
6	Care Provider:	→	Not okay. There are no okays here.
7	Mom:		Okay,
8	Care Provider:		There are **perfects** here.
9	Mom:	→	Okay. **You're perfect.**
10	Care Provider:		**You're perfect.**
11	Mom:		Okay. **You're perfect.**
12	Care Provider:		Absolutely.
13	Mom:		Alright.
14	Care Provider:		Um, I bet you do very well in school.

In line 1, the care provider references how parental height might be related to the daughter's growth. In response, with "So, she's she's she's okay. Right? She's just-", the mom directly requests clarification and reassurance about what this information actually means. The care provider answers the mother's request with the label "Perfect." (line 4), projecting a label of perfection based on results of daughter's height, weight, and growth. The mom's repeating of this label, "Perfect. Okay." (line 5), indicates the mother's affiliation with the care provider's weight-based label as a sign of complete wellness. Research specifically examining the use of

"okay" in conversation has found that "recipients may rely on 'Okay' as a shorthand display that marks: (a) acknowledgment and/or understanding (e.g., confirmation) of, and/or (b) affiliation/alignment (e.g., agreement) with what prior speaker's utterance was taken to be projecting".[39 (p130)]

However, the care provider treats the mother's use of "okay" as not sufficient: "There are no okays here" (line 6) and "there are perfects here" (line 8). This action not only overlooks how mom was using "Okay" to acknowledge and display agreement, but essentially rejects mom's response in line 5 by prioritizing labeling: "Okay" as an inadequate classification for the daughter's health condition. The care provider not just invites, but coerces mom, to more explicitly acknowledge and align with the use of a "perfect" category. In line 9 the mother overtly includes her daughter in the conversation by announcing "Okay. You're perfect", which the care provider's "You're perfect" (line 10) repeats with emphasis. The mother then also repeats the phrase with, "Okay. You're perfect." (line 11), once again showing alignment with care provider's asserted preference for using the "perfect" label. And in line 12, with "Absolutely.", the care provider reaffirms the unconditional stance that "perfect" is the most appropriate label before shifting the topic toward a discussion about school.

In the short sequence evident in Excerpt 1 (above), it is striking that the word "perfect" has been uttered six times. Equally apparent is the care provider's use of medical authority to claim the right to label with "perfect", and to influence mom's adherence to this health classification. While these kinds of 'asymmetries' in knowledge and power are exceedingly common in patient-provider interactions[40,41] the imposition and pursuit of "perfect" by the care provider begins to raise key questions about unique and fundamentally important contingencies of routine pediatric well-child visitations. First, labeling may involve a series of social actions

owned and regulated by care providers as gatekeepers for health classifications. Second, parents can be pressured to accept care provider's labeling assessments. And third, it should be not be overlooked that the daughter plays a mostly passive role in this discussion. Rather, she is the recipient of the final and announced "perfect" label, and must somehow make sense of what "perfect" means in practical terms. Although a "perfect" label may be reassuring at the moment, the relationship of perfectionism to weight and weight-management has a troubling history since previous research has consistently linked drives toward perfectionism with various eating disorder symptoms (e.g., bulimia, anorexia nervosa).[42] Thus, a series of actions surrounding the repetitive labeling of "perfect" weight and health status could inadvertently promote unhealthy linkages, for both mom and daughter/patient, with weight perfection and normalcy in everyday living.

"healthy girl".

Another example of labeling occurs with a six-year-old girl who is at the well-child visit with her mother and brother:

2) Pediatrics 15.17

1	Care Provider 1:	Yeah. Okay. Now let's see how you are growing.
2	Child 1:	A time when, a time when you can leave?
3	Care Provider 1:	Again, same thing. Overall, doing fine with her weight gain. She's 58 pounds
4		today, the 85th percentile, which is fine.
5		*[Overlapping, simultaneous talk: 00:28:05]*
6	Care Provider 1:	Yeah. I mean, it's super tall, like brother.
7	Mom:	Very tall.
8	Care Provider 1:	Um. Yeah. 51 inches, 96th percentile. When we look at her weight for her height,
9	→	she's gonna be in the healthy normal middle range. So, **healthy girl**. Good to see.

In line 1, the care provider invites the mother and daughter to view the growth chart. The care provider first provides an assessment of the growth chart results stating, "Overall, doing fine with her weight gain. She's 58 pounds today, 85th percentile." (lines 3-4). The care provider then marks these results as acceptable, stating, "which is fine." After an intervening discussion (line

5), the care provider then comments that the daughter is "super tall, like brother." The mom agrees with the care provider and echoes with, "Very tall" (line 7). The care provider agrees, then provides further information about the daughter's growth and the proportionality of her growth stating, "Yeah. 51 inches, 96th percentile. When we look at her weight for her height, she's gonna be in the healthy normal middle range" (lines 8-9).

Previous conversation analytic research has found that care providers often invoke the term "normal" to reassure patients of their healthy status.[43] Here, "healthy normal" are conjoined by the care provider and further characterized as a "middle range" for the patient's weight and height. The care provider description is designed as reassuring and indicates a non-problematic weight. In line 9, this positive assessment is extended with "So, **healthy girl**. Good to see". Once again, a label of the preferred identity of "healthy" is used to characterize wellness, which is "Good to see" (line 9).

The above two excerpts provide examples of care providers' tendencies to label children of normal weight as "perfect," "normal," or "healthy" (see Table 8). These actions move beyond simply relaying the growth chart information, to labeling the child's identity as "Perfect" or "Healthy girl". These categorizations extend beyond the assigned tasks of prevention, diagnosis, and treatment outlined by the Academy of Pediatrics.[2] Yet it is nevertheless apparent that care providers recruit social actions such as labeling, asserting, coercing, praising, and reassuring parents and children for having a proportionate weight. These actions are consequential for care, establishing care providers as authorities, yet also providing labels which could be both beneficial and potentially damaging for parents and patients attempting to understand just what "normal" and "healthy" might be.

Labels Referencing Smallness or Thinness

In well-child visits with normal weight patients, care providers often use labels that reference a child's smallness or thinness, despite the potential for these labels to be stigmatizing. The repetitive use of potentially stigmatizing labels in the following well-child visits warrants a brief foray and further theoretical grounding of the sociological concept of social stigma, particularly bodily stigma.

Irving Goffman[44] in his seminal work on stigma, defines stigma as an "undesired differentness" [(p5)] that risks "spoiling" a person's social identity and "has the effect of cutting him off from society and from himself so that he stands as a discredited person facing an unaccepting world". [(p19)] Goffman argues that though some stigmatizing characteristics can be hidden for a time (i.e., mental illness), other characteristics are more readily visible, like bodily differences, and these highly visible and undesired bodily differences can immediately impact the stigmatized person's social interactions. Goffman also notes that care providers are sometimes placed in the position of informing a person of a stigmatizing characteristic that he or she may not have realized otherwise. The stigmatized individual may feel shame and self-loathing as result of his or her difference from the normal population, and managing the stigmatized social identity can include addressing both personal shame and social discrimination. Further mention and exploration of the concept of stigma, shame, and the spoiled identity will be explored in the subsequent chapter on overweight and obese status. However, Goffman's findings are also helpful in this context given that "thinness" and "smallness" can also function as an undesired difference from the normal population and thus comprise a stigmatizing identity.

"She's a smaller girl".

An example of a care provider applying a label of smallness occurs in a well-child visit with a nine-year-old girl and her mother:

3) Pediatrics 26.4

1 Care provider 1: So I'm just showing you her growth. **She's a smaller girl.** That's okay.
2 She's always been **a little smaller**. So she's 55 pounds, 6th percentile because she
3 is not super tall so that's okay. [dubbed] She's kinda tracking and mom and
4 dad aren't that tall. So she is 40, almost 50 inches

In line 1, the care provider presents information from the growth chart, then immediately follows with an identity label stating, "She's a smaller girl". This statement functions as a weight-based identity label because the care provider is using the growth results to define the whole child in terms of her body size. She does not just *have* a smaller weight; she *is* a smaller girl. In this way, the daughter's whole person, is defined by this specific growth chart result. The care provider moves directly from this label to an assessment of reassurance by commenting "That's okay." (line 3). The care provider continues by providing evidence to support the "okay" assessment.

Previous research examining care provider use of evidence during diagnosis has found that when care providers relay a diagnosis they "do not rest on their authority alone. They systematically make their diagnostic reasoning somewhat transparent for the patients, and thus treat themselves as accountable for the evidential basis of the diagnosis".[45(p302)] Here, the care provider makes apparent the reason for the "okay" assessment of the daughter's smallness: that a) "She's always been a little smaller" (line 2), b) "She's kinda tracking" (line 3), and c) "mom and dad aren't that tall" (lines 3-4). These reasons are used as evidence to make transparent the reason for an "okay" assessment in which the daughter's smallness is not of clinical concern.

In this excerpt, the care provider readily applies the label of "smaller girl" to the nine-year-old patient. This label is used to reassure the parent of the daughter's normality given her

body type. The care provider's actions, following this labeling, work to provide an evidentiary basis for the child's healthy, yet smaller weight status.[45] Yet, these actions neglect to take into account that the label "smaller" has potentially stigmatizing connotations.

"He's a slender guy".

A visit with an eleven-year old boy provides a further example of a potentially stigmatizing label used to promote reassurance:

4) Pediatrics 27.2

Line	Speaker		Utterance
1	Care Provider 1:		Yeah? Excellent. Any medical problems? I'm looking through. I'm not seeing
2			much.
3	Dad:		Not really. The only issue is, you know, is is where he falls on the growth curve.
4	Care Provider 1:	→	**He's a slender guy.**
5	Dad:		Yeah.
6	Care Provider 1:		And we don't really have that many points. That's why I asked you if you've
7			been in our clinic before, because we only have kind of like today and
8	Dad:		Yeah, unless it didn't transfer to here.
9	Care Provider 1:		Right, yeah.
10	Dad:		Unless – I'm sure there's a paper.
11	Care Provider 1:		A paper chart or something.
12	Dad:		Yeah.
13	Care Provider 1:	→	Okay. **So, he's slender.** This is his weight. These are like percent curves.
14	Dad:		This is where he's usually been.
15	Care Provider 1:		He usually been– but you know what, I mean, he's kind of – we only have two
16			points, though, on this one, so I can't see. But if this is where he's been, he's on
17		→	curve, and then when you look at how tall he is, **he's not a super tall guy**. So,
18			when you actually plot out his BMI, which is kind of like what he weighs for
19			how tall he is, he actually plots at like the 24th percentile. So, he's not
20		→	undernourished. **He's just not like super, super tall.** So, as long that's kind of
21			determined that that's where he's been, then I'm happy with that. Yeah?

The care provider begins by asking an open-ended question, inviting the parent's concerns with, "Any medical problems?" (line 1). The care provider immediately answers her own question stating, "I'm looking through. I'm not seeing much." The dad mostly agrees, but then provides a *patient-initiated action*,[46] in which he introduces a concern to the care provider stating, "Not really. The only issue is, you know, is is where he falls on the growth curve" (line 3). Here the dad marks the son's growth curve as a potential problem by characterizing it as an "issue" (line

3). The care provider responds to the dad's concern by using a weight-based label for the child with, "He's a slender guy" (line 4). This statement, functions as an identity label by defining the whole child in terms of his specific weight. The child does not just *have* a slender body weight, he *is* a particular type of guy—in this case, a slender guy (line 4).

The dad verbally, although minimally, agrees with this label stating, "Yeah." The care provider then more specifically addresses the parent's concern about his son's weight by discussing the son's growth. In lines 6-11 the care provider mentions that they only have two points of growth on the son's growth curve. In line 13, the care provider fully introduces the growth chart with, "Okay. So, he's slender." Before even providing the growth chart information, the care provider again labels the son as "slender".

Here, it is important to note that previous research indicates that the idealized body for men is increasingly muscular. In pursuit of this ideal, males may turn to unhealthy behaviors such as steroid use and untested supplements.[47–49] Despite the potential for stigma, the care provider repetitively, directly, and unequivocally labels the adolescent boy as "slender" (lines 4 and 13). In this way, the care provider does not appear to adequately account for potential stigma surrounding "smallness" in men, or the fact that this could be a dis-preferred identity. By readily and repetitively applying a potentially dis-preferred label, such as "slender guy," the care provider risks triggering an unhealthy response in the adolescent boy. This is more probable if the possible stigma of this label is not fully understood by the care provider and thus not fully addressed.

The care provider continues (line 13) with, "This is his weight. These are like percent curves". The dad acknowledges the growth information and confirms (line 14) that this is where the son's growth curve has "usually been." The care provider acknowledges and repeats the

dad's exact words in line 15 with, "usually been." The care provider then shifts the conversation to argue for how the son's weight is not clinically problematic with, "but you know what I mean, he's kind of – we only have two points though on this one, so I can't see. But if this is where he's been, he's on his curve" (line 15). Previous research has found that I-mean-prefaced utterances can be used as 'defensive mechanisms' to seek affiliation from the recipient when providing a potentially complain-able utterance.[50] Although the care provider is not presenting a particular complaint, the care provider is seeking the dad's affiliation for the counter-position that the son's weight is not a clinical "issue," despite the fact that the dad has presented the son's weight as an important issue. Thus, the care provider's I-mean-prefaced utterance delicately functions to seek affiliation from the father while defending the potentially problematic stance that, despite the father's concern, the son's low weight is not of clinical importance. Again, consistent growth on the growth curve is used to provide assurance that's the son's slender weight is not of clinical concern. The care provider continues to assure the parents that the son's slenderness is not an issue by pointing to the son's height and providing another label noting, "and then when you look at how tall he is, he's not a super tall guy" (line 17). In this way, "not super tall" (line 17) is used to normalize, "slender guy," (line 4) implying a healthy symmetry between a small weight and a small height.

The care provider then further explains and again labels the child, "So, when you actually plot out his BMI, which is kind of like what he weighs for how tall he is, he actually plots at like the 24th percentile. So, he's not undernourished. He's just not super super tall." (lines 17-20). Here the care provider is careful to note that the son's weight is not clinically problematic with the statement, "So, he's not undernourished." (lines 19-20), which emphasizes for the dad that no behavioral modifications are required or needed. This is an important objective for this particular

interaction, as the dad initiated the son's weight as an "issue" (line 3). To further argue for the son's weight as an aspect of the son's body type and not an issue, the care provider again turns to labeling. In this case, using another extreme case formulation,[51] with "not like super super tall" (line 20). This label is an upgraded version of the label provided in line 16, "not super tall", adding an additional "super". Not being "super super tall", provides a roundabout implication that the son's height is just under normal, and thus not an issue relevant to the well-child visit. The care provider closes by providing a final, bottom-line reassurance with, "So, as long that's kind of determined that that's where he's been, then I'm happy with that" (line 20-21).

In this well-child visit, the care provider uses the labels of smallness and thinness throughout the discussion of the growth chart as a means of addressing and normalizing the slenderness/smallness as something the child *is,* rather than a clinical condition that requires treatment. As with the example before, the care provider in this well-child visit readily applies labels of smallness and thinness to the 11-year old boy despite the fact that this boy may view smallness and thinness as a dis-preferred or even an stigmatizing identity.[47–49]

When Care Providers Do Not Provide Identity Labels

As mentioned above, care providers' use of the growth chart to label normal weight patients was surprisingly pervasive, occurring in the majority of well-child visits. Thus, the instances in which care providers did not label the child, provide examples of an alternative way of communicating the bottom-line meaning of the growth chart and reassuring the parent of the child's healthy status without turning to potentially harmful or stigmatizing labels to do so.

"he's a skinny mini".

A well-child visit with an 11-year-old boy and his brother and parents provides an example of a care provider *resisting* applying a label of smallness or thinness to the child:

5) Pediatrics 38.1

1	Care Provider:		Exciting. Wonderful – wonderful. Let's look at this. Here's your weight getting
2			bigger – bigger – bigger – bigger – bigger – bigger – bigger – bigger. And your
3			length so getting really bigger – bigger – bigger – bigger – bigger so you're at
4			the 75th percentile.
5	Mom:		Wow, I'm – for weight?
6	Care Provider:		For height.
7	Dad:		No, height.
8	Mom:		Oh…
9	Care Provider:		That's height.
10	Mom:	→	For weight **he's a skinny mini.**
11	Care Provider:		No, yeah. For weight he's getting bigger but he's way down here.
12	Mom:	→	Yeah, well I'm worried about that because **he's so skinny**.
13	Care Provider:		It's okay.
14	Mom:		All right.
15	Care Provider:		Here's his body mass index, so believe it or not, he is getting a little bit bigger
16			then but I think he might be a little related to the other two adults here in the
17			room who are not have body mass indexes that are very high so –
18	Mom:		Okay.
19	Dad:		But she's cheating though.
20	Care Provider:		Yeah.
21	Dad:		What?
22	Care Provider:		So on the flip side –
23	Mom:		That – that's ridiculous. He probably thinks that something – I just got diagnosed
24			with RA so he's –
25	Care Provider:		Oh.
26	Mom:		So I've lost – just dropped – lost all this weight. But I'm not cheating – I'm not
27			cheating I'm trying –
28	Care Provider:		Purposely.
29	Dad:		I didn't say it was a good thing.
30	Care Provider:		Right. So, you know looking back though, when is the last time I saw you? A
31			year ago. So that tells me you've been healthy. So looking at that relative to
32			weight. Okay, so food at this age?
33	Mom:		He eats tons.
34	Care Provider:		Yeah.
35	Dad:		Oh, yeah.
36	Care Provider:		But it's all going into –
37	Mom:		But he runs everywhere, yeah.
38	Care Provider:		Exercise and growth. You know, Getting bigger – bigger – bigger. So what kind
39			of – what kind of sports do you like to play?
40	Child:		Baseball.
41	Care Provider:		Baseball. And what position do you like to play?
42	Child:		Center field.
43	Care Provider:		Center field. Okay. Good. Good. Good.
44	Dad:		They both-They both made –
45	Mom:		All-Stars.
46	Dad:		All-Stars this year.
47	Care Provider:	→	Oh congratulations. Wonderful. So no, **I'm not worried about – I'm not**
48			**worried about his weight.**

The care provider introduces the topic of weight and growth energetically and inclusively commenting, “Here’s your weight getting bigger – bigger – bigger – bigger – bigger – bigger – bigger – bigger. And your length so getting really bigger– bigger – bigger – bigger – bigger you’re at the 75th percentile.” The mom responds to this information with surprise and a request for clarification, commenting, “Wow, I’m–for weight?” (line 5).

Both the dad and the care provider clarify that the 75th percentile refers to the son’s height. The mom then follows this clarification, with a label of her son based on his weight status stating, “For weight he’s a skinny mini.” (line 10). Notably, the label of “skinny mini” is likely a dis-preferred label for an 11-year old boy.[49]

Rather than up-taking this label, the care provider here addresses the mother’s concerns directly with, “No, yeah. For weight he’s getting bigger but he’s way down here.” (line 11). Again, the mother repeats her concern for her son’s weight, framing the identity label as a worry, “Yeah, well I’m worried about that because he’s so skinny.” (line 12). The mother uses an extreme case formulation,[51] “so skinny,” to argue for her position of the son’s weight as problematic.

Again, the care provider resists taking up this label and instead addresses the worry itself, stating, “It’s okay.” (line 13). The mother responds with “All right.” (line 14). The mother’s minimal response (line 14) indicates that this reassurance might not be enough. The care provider continues by clarifying and explaining the results of the growth chart and BMI within the framework of parental height and weight. The care provider comments, “Here’s his body mass index, so believe it or not, he is getting a little bit bigger then but I think he may be a little related to the other two adults here in the room who are not have body mass indexes that are very

high so." (lines 15-17). The mom still does not appear convinced and answers minimally, with "Okay" (line 18).

In lines 18-28 the parents briefly discuss, somewhat off-topically, how the mom's current thinness is related to her Rheumatoid Arthritis (RA). In line 30, the care provider re-directs the conversation back to the concern about the child's growth, noting, "Right. So, you know, looking back though, when is the last time I saw you? A year ago. So that tells me you've been healthy. So looking at that relative to weight. Okay, so food at this age?" Here, the care provider again emphasizes that the child is healthy, without overtly labeling the child based on weight status. In lines 32-46 the care provider and parents discuss the child's eating and exercise habits. Finally, in lines 47-48, the care provider provides clear reassurance and bottom-line understanding of the child's health status stating, "So, no, I'm not worried about –I'm not worried about his weight."

This excerpt provides a compelling example of a care provider resisting labeling a child "skinny" or "small" despite the mother's pressure to do so. Instead, the care provider directly addresses the mother's worry and reassures the mother of the child's healthy status by providing information about the child's growth (lines 15-17) as well as overtly stating, "I'm not worried about his weight" (lines 47-48). Thus, reassurance and clarification are provided without the use of potentially stigmatizing labels.

In summary, in the majority of well-child visits with normal weight patients, care providers overtly label children based on their weight status. Using labels of perfection, normalcy, and health, care providers reassure parents and children of the child's healthy status. Care providers also use labels of smallness and thinness to reassure. However, in these cases the care providers reassure parents of their child's healthy status by noting that the child's smallness

and thinness are an artifact of the child's body type or identity, rather than a clinically relevant problem, and thus no behavioral modification or further intervention are needed.

Linking a child's weight to specific identity labels, including labels of perfection/normalcy/healthy as well as smallness/thinness, has the potential to be harmful for several reasons. First, providing a positive identity label based on weight (i.e., you're perfect) links weight status to worth and worthiness, an unhelpful and potentially dangerous connection. Secondly, the ready application of potentially stigmatizing labels of smallness and thinness (i.e., "She's a smaller girl")[47–49] risks harming a child's self-image, especially when these words come from an authority figure. Notably, there were also instances in which care providers do not label the child. These instances indicate that, although less prevalent, there are effective and alternative ways to communicate the meaning of the growth chart without resorting to potentially stigmatizing or harmful weight-based labels to do so.

Excluding Children in Discussions of Weight

Another pattern that emerged when analyzing well-child visits with normal weight patients is that, in the vast majority of instances, care providers verbally direct the discussion of weight exclusively to parents. Although understandable, not directly including children in discussions about the growth and care of their own bodies, misses an opportunity to build care-provider patient rapport and to educate and engage the child about his or her own body. In fact, past research has indicated that directly addressing children during pediatric visits promoted physician-child rapport, child recall of treatment recommendations, and children's greater preference for an active role in their health care and medical knowledge.[52] Additionally, previous research has also confirmed that children value communication with their care provider, specifically, having their questions listened to and answered and having the care provider use

understandable language without medical jargon.[53] In the context of discussions of the growth chart and BMI, care providers not directly addressing the child or using words they understand may promote a child's lack of personal ownership about the care and keeping of their bodies.[52] If children are empowered to engage with discussions about their bodies, and provided with knowledge about positive health choices, the more likely they may be to take the care of their bodies seriously and more apt to discuss these issues with trusted adults.

Not Including Children in Discussions of Weight

"she's growing well".

In this next excerpt, the care provider is discussing the growth chart of a kindergarten-aged girl of normal weight. This discussion is verbally directed to the mother. The child is never directly addressed during this interchange:

6) Pediatrics 4.7

1	Care Provider 1:		Okay. And I'm bringing up her growth curves, and I'm happy to show that **she's**
2		→	growing well, so **she's** gaining weight fine.
3	Child 3:		I do grow well! I do grow well!
4	Care Provider 1:	→	So, today, **she's**…oh, why isn't my cursor working?
5	Child 3:		I do grow well! I do grow well, too!
6	Care Provider 1:		Okay. I'll go back through this. Oh, my computer just died.
7	Mom:		It froze.
8	Care Provider 1:		It froze.
9	Mom:		I'm lucky like that.
10	Care Provider 1:		So am I.
11	Mom:	→	How much does **she** weigh?
12	Care Provider 1:		I can't tell you. Well, actually, I mean **she's** about [inaudible] 44 pounds today.
13	Mom:		Yes.
14	Care Provider:		Sound right?
15	Mom:		Yeah
16	Care Provider 1:		Which is about the 50th percentile. But I can't tell you anything else right now,
17		→	which is very frustrating. Okay. And any other concerns for **her** development,
18			how **she's** doing in school?

The care provider introduces the topic of the growth chart, stating in line 1, "Okay. And I'm bringing up her growth curves". From the onset, the discussion is verbally directed only to the mother. The care provider continues, "and I'm happy to show that she's growing well, she's

gaining weight fine." Here the care provider provides a positive assessment of the growth chart. This assessment is once again directed at the parent.

Yet, in line 5, the girl suddenly breaks into the conversation again exclaiming, "I do grow well! I do grow well too!" Despite the daughter's self-inclusion, the care provider and parent do not include her in the discussion and continue to discuss the growth chart. The mother asks, in line 11, "How much does she weigh?" The care provider states, "Well, actually, I mean she's about [inaudible] 44 pounds today" (line 12). Notably, the child is talked about rather than included. The care provider uses medical jargon with words like "50th percentile" (line 16). This jargon is not explained to the child.[53] Understandably a kindergarten-aged girl may not fully or even partially comprehend the meaning of a growth chart, but inclusion in the discussion, in at least a basic way, may be an important step in understanding her own body and the care and growth of her body. Here it is a missed educational opportunity, as the young girl is clearly interested in her own growth.

"his weight is fine, totally fine".

In excerpt 7, with a six-year-old boy, the care provider is discussing the growth chart. Once again, the care provider verbally directs the discussion exclusively to the mother, even when the child attempts to enter the conversation:

7) Pediatrics 28.7

1	Care Provider:	→	So, vision, hearing, blood pressure are all normal. I'm going to show you **his**
2			growth chart. So, **his** weight is fine, totally fine except when they measured **him**,
3			**he** shrunk a little bit. So, that made his body mass index-
4			**[Inaudible cross talk]**.
5	Care Provider:	→	So, it made **his** body mass index go, shoot up.
6	Mom:		Yeah.
7	Care Provider:		But that's artificial. So, I'm not worried about that.
8	Child:		Is that my body?
9	Mom:	→	That's that's how big **your** body is, how strong **you're** getting.
10	Care Provider:		So, I don't want you to have any concerns about that, even though there was a
11			big jump on BMI.

12 Child: Stinky feet.
13 Care Provider: He does not have any vaccines due today.

In lines 1-2, the care provider introduces the growth chart result with the phrase, "I'm going to show you his growth chart." The care provider continues to assess the growth chart, "So, his weight is fine, totally fine" (line 2). Here the care provider is careful to emphasize that the child's weight is within a healthy range, by providing an assessment of "fine" (line 2), as well as an extreme case formulation[51] of that assessment, "totally fine" (line 2). In lines 2-3 the care provider next explains that the child's BMI has gone up because of a previous mis-measurement. The care provider communicates overt reassurance to the mother clearly stating, "So, I'm not worried about that." (line 7). However, the language used throughout this interchange is elevated and includes technical jargon with phrases like, "growth chart" (line 2) and "body mass index" (line 3). Words and phrases that a six-year old boy would likely not understand without explanation.

As with the previous excerpt, the child attempts to enter the conversation with, "Is that my body?" (line 8). The care provider does not answer the child's question. This is especially notable, given that one of the factors children listed as important to them in pediatric visits was care providers answering their questions.[53] Instead, the mom addresses the child and answers, "That's that's how big your body is, how strong you're getting." (line 9). The care provider continues to discuss the BMI with the mother in lines 10-11, as if the interchange with the child had not occurred. Once again, here appears to be a missed opportunity for building rapport and educating the patient about his own body. The child indicated interest in his body by directly initiating a question. However, this interest was not addressed by the care provider, although it was addressed by the mother.

Directly Addressing the Child: Engagement and Education

As mentioned previously, in the vast majority of well-child visits with normal weight patients, care providers talked to parents *about* the child's growth chart and did not verbally include the child. However, this was not the case in every visit. There were several visits with normal weight patients where the care providers directly addressed the child when discussing the growth chart and BMI. Additionally, in most of these cases care providers also included an educational component where the care provider explained the meaning of the growth chart and/or BMI. The fact that care providers tended to include more education when directly addressing the child, indicates that directly addressing the child may imply commitment to explain the growth chart and BMI using words the child can understand and education to make these words meaningful. Thus, child engagement and education may begin, at least linguistically, by simply including the child in the discussion.

"your growth chart".

A well-child visit with a nine-year-old girl provides an instance in which the care provider linguistically includes the child in the discussion about her growth chart:

8) Pediatrics 24.4

1	Care Provider:	→	Let's take a look at **your** growth chart. Here we are. Perfect. Here **you** are way
2			down here when **you** were four. And now, **you're** way up here. Now, **you're** in
3			the–
4	Mom:		Oh, really?
5	Care Provider:		Uh huh
6	Mom:	→	Okay. So, **she's** in what percentile?
7	Care Provider:	→	Today, **you're** at the 42nd percentile.
8	Mom:		Yay.
9	Care Provider:		Just fine. Perfect. Because **you're –**
10	Mom:		So, but **you** used to be in the – what? Twenty-five or or?
11	Care Provider:		Here we are. Here **you** were at the 30th.
12	Mom:		The 30th.
13	Care Provider:		Here **you** are at the 18th.
14	Mom:		This is the weight?
15	Care Provider:	→	This is **your** weight.
16	Mom:		Oh, this is the weight. So, weight is good.

17 Care Provider: → So, if **you** took 100 girls **your** age, **you** would weigh more than 42 of them. And
18 what? Fifty-eight of them would weigh more than **you**. But **you're** just perfect.
19 Mom: **You're** right in the middle.

In line one, the care provider directly addresses the child using the personal pronoun, "your," with "Let's take a look at your growth chart". By using the direct personal pronoun, "your" the care provider is clearly marking the information as information the child is allowed to interact with and respond to. The mom interrupts with a clarifying question, referring to the daughter in the third person, "So, she's in the what percentile?" (line 6).

Notably, the care provider resists the mother's approach of discussing the daughter in the third person, and instead (again) directly addresses the daughter with, "Today, you're in the 42nd percentile" (line 7). The mom responds to this information and treats it as good news, responding with "Yay." (line 8). The care provider also valences this news positively, labeling the growth as, "Just fine. Perfect." (line 9). The mom explains that the child used to be at a lower growth percentile (line 10).

In line 17, the care provider educates the parent and child on the meaning of the growth chart stating, "So, if you took 100 girls your age, you would weigh more than 42 of them. And what? Fifty-eight of them would weigh more than you. But you're just perfect." Here the care provider explains the growth chart with the concept of 100 children of the same sex and age, and the child's relation to these children. This information is linguistically addressed to the child throughout the explanation, tacitly allowing and including the child to enter in to the discussion. Furthermore, the language used is more appropriate to a child and avoids technical jargon in favor of explaining what the terms actually mean in relation to the child (e.g., "if you took 100 girls your age, you would weigh more than 42 of them"). In fact, the care provider's explanation here provides an excellent exemplar of how to include the child and explain potentially

confusing information using words a child could understand. This is especially important given that previous research has indicated that children value when the care provider takes the time to avoid jargon and use understandable language.[53] The mom further explains this information for the child noting, "You're right in the middle." (line 19). Thus, the care provider and parent, eventually work together to explain the growth chart information using more understandable and child-friendly language.

Although the discussion is linguistically delivered to the child, with the personal pronouns "you" and "your," it is the mother who interacts with the care provider. Notably, the care provider never directly asks the daughter a question or overtly requests participation. Furthermore, even if the care provider had asked the child a question, this would not necessarily guarantee participation, as the child may not respond to the question. In fact, a previous study examining care provider question-asking, found that when care providers asked children a question, children only responded 65% of the time (as compared to parent's 93% response rate).[54] Engaging children during pediatric visits may not be a simple task. Nonetheless, the care provider here overtly includes the child in the discussion about her weight, tailors the language to be understandable to her, and takes a moment to provide education about the meaning of the growth chart.

"you're 75 pounds".

Similarly, in excerpt 9, the care provider introduces the growth chart with a 10-year-old girl and her mother and father:

9) Pediatrics 20.5

1 Care Provider: → Alright, So, **you're** 75 pounds, it's the 55th percentile. Do **you** know what that
2 means?
3 Child: No.
4 Care Provider: → So, if **you** lined up 100 girls **your** age, **you'd** be right in the middle in terms of
5 having a healthy, healthy weight. So, same thing with **your** height. **You're** 54.7",

6			the 53rd percentile. So, again, if **you** lined up 100 girls **your** age, ten years old,
7			**you're** right in the middle.
8	Mom:	→	**She's** actually always been that way, too.
9	Care Provider:		She's always been right average.
10	Mom:		**She** always has about 50, yeah.
11	Care Provider:	→	Yeah, and so when you were looking at the BMI, which is Body Mass Index,
12			looking at how **her** height is for **her** weight, **her** weight is for **her** height. Of
13			course, **she's** very healthy and normal.
14			[indistinguishable]
15	Mom:		Yeah, I told her **she** was perfect.
16	Care Provider:		I agree with **your** mom

In line 1, the care provider directly addresses the child using the direct pronoun "you're," linguistically including her in discussion about her growth. The care provider then informs the child of her weight and the percentile of her weight. Following this information, the care provider directly asks the child if she understands. Notably, the child actually responds to the care provider's question, which is not always the case in pediatric visits.[54] The child replies, briefly, with "No." (line 3). In line 4, the care provider responds to the child's answer that she does not know what the technical information means. In this way, the care provider embraces the educational opportunity made available by the child's answer. The care provider explains the meaning of the weight and weight percentile. In lines 4-7, the care provider describes how the growth chart is based on percentiles, using simple terms without jargon.[53] Specifically, the care provider explains that "if you lined up 100 girls your age, you're right in the middle." Although this is a different care provider than in the previous excerpt 8 above, almost identical language is used to explain the child's growth. As with the example above, the care provider here takes the time to explain the child's growth in reference to where the child fits compared to others. The care provider avoids jargon and uses words appropriate for a child.[53]

Once again, the care provider simply begins by directing the conversation to the child, with the personal pronoun "you're" in line 1. The care provider asks the child a question and

responds to the child's answer with education. This interaction provides an example of a care provider who engaged, informed, and empowered the patient when discussing the growth chart and weight.

Nonetheless, even this example indicates a propensity to exclude the child in medical discussions. Later, in lines 12-13, the care provider reverts to exclusively discussing the child's BMI with the parents using third person pronouns for the daughter. In this instance, the care provider talks about the child to the parent using "her," rather than the "you're" used above. The vast majority of well-child visits with normal weight patients linguistically exclude children from these discussions. That the care provider reverts back to the parents and away from the child is not surprising. In fact, it appears that the default behavior for care providers is to discuss the child in the third person with the parents. It seems that to linguistically include the child is to defy this default behavior, and this defiance appears to include more education than when the child is excluded. In general, direct communication with the child from the onset seems to co-occur with the use of more understandable language as well as child-tailored education about the meaning of the growth chart and BMI. Education appears to flow directly from the inclusion of the child in the discussion.

Food Inventories and Little Discussion of Physical Activity

As mentioned in chapter one, there were three main portions of the well-child visit where diet, physical activity, and weight were discussed. These were: 1) the discussion of the child's diet, 2) the discussion of physical activity, 3) and the review of the growth chart and BMI. The majority of the current chapter is focused on interaction during the review of the growth chart and BMI. However, it is worth briefly noting several patterns that emerged in the portions of the well-child visit in which the care provider discusses physical activity and diet.

Physical Activity

In the majority of well-child visits with normal weight patients, care providers only minimally address physical activity (e.g., asking two questions or less), and often neglect to mention physical activity at all. When physical activity is mentioned it is often mentioned using only a single question. In general, physical activity is not framed as a priority for normal weight patients. The questions the care providers ask about physical activity, when asked at all, tend to merely address the presence or absence of a sport or activity, not the duration or frequency. Although important for weight management, the benefits of physical activity extend beyond weight management alone. In fact, physical activity enhances mental health and mood, improves bone and muscle strength, diminishes the risk of type 2 diabetes, metabolic syndrome, cardiovascular disease, and some cancers, and extends life expectancy.[55] Thus, by neglecting to fully assess and educate patients on physical activity, an important opportunity for promoting this crucial health behavior is lost.

Food Inventories

"Do you eat healthy foods like fruits and vegetables".

Diet is discussed in almost all of the well-child visits with normal weight patients and these discussions take the form of food inventories. Specifically, care providers ask a series of questions to assess the child's eating behaviors. With normal weight patients, weight management is not the focus of the discussions. Instead, care providers ask parents and sometimes children if they are eating specific foods that contain particular nutrients (e.g., calcium and iron). The following excerpt provides a fairly typical example of how food is discussed in well-child visits with normal weight patients. The excerpt below includes a five-year-old girl, her mother, and two siblings:

10) Pediatrics 4.6

1	Care Provider 1:	Do you drink milk?
2	Child 3:	Mm-hmm.
3	Care Provider 1:	Okay. Do you eat healthy foods like fruits and vegetables?
4	Child 3:	Mm-hmm.
5	Care Provider 1:	Okay.
6	Child 3:	And I like green beans.
7	Care Provider 1:	Okay. How's her appetite in general?
8	Mom:	Oh my god. [inaudible]
9	Care Provider 1:	Okay. So, doing okay.
10	Mom:	Very okay.
11	Care Provider 1:	Okay. And getting some good iron from meats or beans or tofu?
12	Mom:	Yeah, yeah. Um if not that, um, they take a daily vitamin because I'm anemic, so
13		I want to make sure that they're …
14	Care Provider 1:	Getting some good nutrition and iron.

In the above excerpt, the care provider assesses if the child is drinking milk (line 1), consuming fruits and vegetables (line 3), having an appropriate appetite (line 7), and getting iron from meat or other sources (line 11). The interaction moves quickly and is propelled forward by the care provider. Specific questions about particular foods or food groups are asked and answered, and then the care provider moves on to the next question. The food inventory portion of the well-child visits, although not particularly conversational, tends to be fairly thorough, assessing specific types of food and food groups. The thoroughness of the food inventory discussion highlights the lack of thoroughness in the physical activity discussion, indicating that nutrition is given precedent over physical activity.

Chapter Summary

In summary, the current chapter explored key findings of care provider, parent, and child communication about weight, diet, and physical activity during well-child visits with normal weight patients. First, in the majority of well-child visits with normal weight patients, care providers label the child's identity based on the child's weight status as reported from the growth chart and BMI. Care providers use two main types of labeling: labels of perfection and health

and labels referencing smallness or thinness. When care providers use weight to label patients as healthy, perfect, or normal, the key social action of the labeling appears to be reassuring the parent of the child's healthy status. However, in so doing, the care provider risks promoting an unhealthy tie of weight with perfectionism and worth. When care providers label the child in reference to their smallness or thinness, the key social action also seems to be reassurance. In this case, care providers reassure parents and children that the child's smallness and thinness are an artifact of the child's body type or identity, rather than a clinically relevant problem. However, the ready application of potentially stigmatizing labels of smallness and thinness (ie., She's a smaller girl)[47–49] could risk harming a child's self-image, especially when these words come from an authority figure. Nonetheless, some care provider resist labeling the patients based on weight status, even when pressured by a parent to do so. These care providers illustrate that it is possible to clearly communicate the results of the growth chart and reassure parents without turning to potentially harmful or stigmatizing weight-based labels to do so.

Second, in the vast majority of well-child visits with normal weight patients, care providers verbally exclude children in discussions of BMI, growth charts, and weight – directing these discussions almost exclusively to parents, and thus missing an opportunity to build patient rapport and to educate and engage the child. Nonetheless, there are several visits with normal weight patients where the care providers directly address the child when discussing the growth chart and BMI. Notably, in most of these cases, care providers also include an educational component where they explain the meaning of the growth chart and/or BMI. The fact that care providers tend to include more education when directly addressing the child, indicates that directly addressing the child may imply a commitment to explain the growth chart and BMI using words the child can understand and education to make these words meaningful. Thus, child

engagement and education may begin, at least linguistically, by simply including the child in the discussion. Directly communicating with the child and providing education and engagement is a worthy endeavor, especially given that directly communicating to the child during pediatric visits has been found to promote physician-child rapport, child recall of treatment recommendations, and children's greater preference for an active role in their health care and medical knowledge.[52]

Third, in the majority of well-child visits care providers and parents only minimally discuss physical activity, most often including only one to two questions, and often neglect to discuss physical activity at all. Conversely, nearly every well-child visit with normal weight patients includes a discussion of nutrition, usually in the form of a thorough food inventory question and answer section. The thoroughness of the nutrition portion when contrasted with the minimal treatment of physical activity, highlights that in current well-child visits physical activity may not be given the attention it warrants.

Link to Quantitative Findings

As described in Chapter Two, 89.7% of parents reported that the care provider discussed diet, physical activity, and weight with them. The qualitative analysis of the well-child visits confirm and contextualize how these conversations proceed with normal weight children, who are not at immediate risk for overweight or obesity. As described above, the conversations focus on reassurance of the child's health (i.e., using weight-based labels) and routine assessment of dietary needs.

Additionally, as outlined in Chapter Two, a 2-tailed test revealed a strong, positive correlation between child age and parent-reported satisfaction with the care provider's communication about weight, diet, and physical activity, *rho* (30)=.51 p=.004, with higher child age associated with higher parent-reported satisfaction with the care provider's communication

about weight, diet, and physical activity. The above qualitative analysis may help elucidate why this might be the case. Specifically, in excerpts 8 and 9 (above), the care provider engages with the child. Notably, the children in these well-child visits are on the older side of the targeted age range—9 and 10-years-old, respectively. Conversely, in excerpts 6 and 7, the care provider excludes the child from the conversation about weight, diet, and physical activity. Notably, the children in excerpts 6 and 7 are kindergarten age (excerpt 6) and 6-years old (excerpt 7). One reason why parent satisfaction with care provider communication about weight might be higher for parents with older children, could be that it is simply easier for the care provider to engage children who are older rather than children who are younger. More research would need to explore if this pattern is similar in additional well-child visits.

Chapter 4: Well-Child Visits with Overweight/Obese Children

The current sample included well-child visits with one patient approaching overweight status (defined as 84th percentile) and four overweight/obese patients (defined as 85th percentile or above).[35] For the sake of brevity, I will refer to the sample as overweight/obese patients for the remainder of the chapter. When specifically discussing the well-child visit with the approaching overweight patient, I will note the approaching overweight status. Additionally, please note that child BMI was calculated based on the parent report of the child's height and weight in the post-visit questionnaire. However, 2 of the 6 parents in the current sample did not provide height and weight information or did so incorrectly. For these, the child's weight status was determined using the transcribed well-child visit as well as fieldnotes. However, exact BMI percentiles for these two patients are not provided in the analysis below, and separate counts for overweight and obese status, which would be based on BMI percentiles, cannot be provided. Finally, while this appears to be a small sample, the moments comprising these encounters, and selected for detailed analysis in this chapter, reveal essential findings and insights about how being overweight gets managed during pediatric well-child visits.

Figure 5 outlines the key findings for care provider communication with overweight/obese patients and their parents.

As depicted in Figure 5, the current chapter explores several key findings for care provider, parent, and child communication about weight, diet, and physical activity with overweight/obese patients. First, care providers do not provide weight-based labels with overweight/obese patients. Information from the growth chart and BMI is not tied to child identity and is not used to reassure. Second, care providers seem to apply a further layer of euphemism and engage in *excessive abstraction* when discussing the child's weight. This includes using language that partially or even fully removes the child from the overweight or

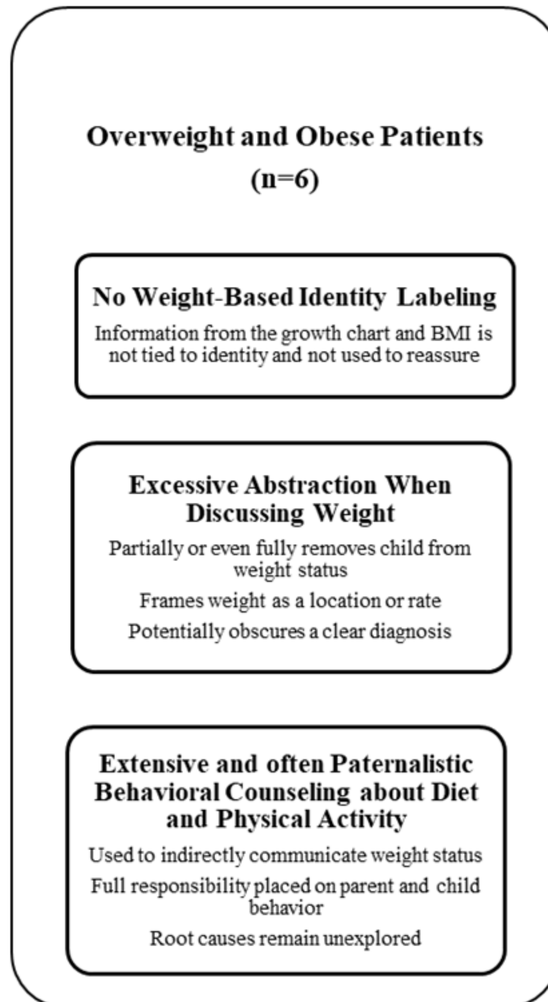

Figure 5: Key findings for overweight and obese patients (n=6).

obese weight status. Third, in lieu of a clear communication of weight status, care providers supplement with extensive and potentially stigmatizing behavioral counseling about diet, physical activity, and weight. This is used to indirectly communicate weight status. Yet, in so doing, full responsibility for the overweight or obese status of the child is placed on the parent and child's behavior. Specifically, when care providers use an overemphasis on diet and physical activity to communicate and address high weight status, the implication is that the high weight is a direct cause of parent and child misbehavior. This strategy for communicating weight status has the potential to further stigmatize the parent and child, while also neglecting possible root causes of the overweight or obese status, like adverse childhood experiences. In fact, previous

research on adverse childhood experiences (see: ACE studies) has found that experiences like parental divorce or abuse can function as risk factors for substance abuse problems, lower physical and mental health, and lower health-related quality of life.[56] Adverse childhood experiences have even been linked to adult obesity.[57]

Key to the understanding and analysis below is the concept and theory of stigma and the spoiled identity. As described in the previous chapter, Goffman (1963) explains how stigma presents an "undesired differentness"[(p5)] that threatens to "spoil" a person's identity in the eyes of others.[44] Others viewing the person's undesired difference may, as a result, unfairly attribute other undesired characteristics to the stigmatized person (i.e., overweight status indicates laziness). In the following analysis both care providers and parents display their awareness of the potential stigma surrounding overweight and obese status for both parents and children. Importantly, care providers and parents interact with stigma by mitigating, avoiding, and even inadvertently perpetuating the stigma surrounding overweight and obese status. The findings make clear how weight-based stigma continues to persist and influence the treatment and care of overweight and obese child patients.

No Weight-Based Identity Labeling

With overweight and obese patients, care providers do not provide weight-based identity labeling. This is especially noteworthy given that in the vast majority of well-child visits with normal weight patients, care providers follow the growth chart and BMI information with an identity label (i.e., "you're perfect" or "you're a lean guy"). Care providers applied no such labels here—either to reassure the patient of their normality, or to warn them of their problematic weight status. This signifies a variance in communication patterns between how providers interact and make sense of weight and identity with normal weight versus overweight and obese

patients. In these ways, both care providers and parents enact avoidance for the potential stigma surrounding an overweight or obese health status.[44]

"We don't like it to get above that, okay"

The excerpt below involves a 10-year-old boy who is approaching the 85th percentile for weight:

1) Pediatrics 10.16

Line	Speaker		Utterance
1	Care Provider:		Okay. So you like to have their vision checked by the optometrist.
2	Mom:		Yes.
3	Care Provider:		That's fine. Yeah. And your hearing, you passed, so let's look at your growth
4			chart.
5	Mom:		He actually does wear glasses, by the way.
6	Care Provider:		Oh, okay.
7	Mom:		I don't know why you're not wearing them [inaudible]. All of us do, but –
8	Care Provider:	→	Okay. So, as you're going along, your weight has gone up, but at about the **same**
9			**rate** as it did last year. **It's the same place** on the chart, I should say. So at about
10		→	the-almost the 85th percentile. **We don't like it to get above that, okay?** So let's
11			look at your length. And it is about the 75th percentile. So you're pretty tall as
12		→	well. Now this is the body mass index, and we, again, **don't want it to get above**
13			**the 85th**, and you're right at the 85th. So this is why your mom and I are
14			talking about –
15	Mom:		Exercising.

During this segment of the well-child visit the care provider is delivering results of several different tests. In line 1, the care provider recommends the child have his vision checked by the optometrist. In line 3, the care provider informs the patient that he has passed the hearing test. Within the same utterance, the care provider continues to move the conversation to the growth chart with, "so let's look at your growth chart." Notably, the care provider includes the child in the discussion with "let's" and "your", thus framing the conversation as available for the child's participation (see Chapter 3 for a discussion of child inclusion). The mother interjects in line 5, referencing back to the care provider's comment about the optometrist: "He actually does wear glasses, by the way." The care provider briefly acknowledges the mother's comment and marks it as somewhat unexpected with, "Oh, okay." (line 6). Essentially, the care provider had begun to

launch into a discussion of the growth chart (line 1) yet was forestalled by the mother's comment about glasses. The mother continues to discuss the son's eyesight with, "I don't know why you're not wearing them. All of us do, but--." (line 7).

Here the care provider interrupts the mother, and directs the attention to the growth chart with, "Okay. So as you're going along, your weight has gone up, but at about the same rate as it did last year. It's the same place on the chart, I should say. So at about the –almost the 85th percentile. We don't like it to get above that, okay?"(lines 8-10). In lines 8-10 the care provider outlines the information of the growth chart and marks it as potentially problematic with "We don't like it to get above that, okay?" This question itself (e.g., "We don't like it to get above that, okay?") is phrased quite delicately and indirectly. The care provider begins the question with, "We" and abstracts the child's weight to be an "it" that should not exceed a certain point "above that" (line 10). With this question, the care provider cautions the child about further weight gain, without overtly mentioning the child's high weight status.

With normal weight patients, weight-based identity labels are used by the care providers to communicate and reassure patients of the results of their growth chart as normal and not in need of clinical attention (e.g., "She's a smaller girl" see: Chapter 3). Here we find no such reassurance, and no such labeling. The care provider here is careful to not use a potentially stigmatizing[44] weight-based identity label to communicate the meaning of the growth chart and BMI information. Instead, the care provider continues with the health information, and leaves the parent and child to determine what this information might mean for the child's identity and weight status.

The care provider next relays the child's height with, "So let's look at your length. And it is about the 75th percentile. So you're pretty tall as well." (lines 10-12). Here the care provider

labels the child as tall. Notably, this is not a weight-based label as it does not define the child in terms of weight. Furthermore, the care provider's "as well" references that the child's weight is also high, but weight is never used to provide a label. Instead, the care provider turns to the results of the BMI (lines 12-13) to convey the health information.

Previous research with trainee care providers found that the majority favored language like "BMI," "weight," and "unhealthy BMI" when discussing obesity with patients.[58] The majority of trainees also dis-preferred labels like "obese" and "obesity" and instead favored euphemisms. The care provider here also avoids weight-based labels and instead focuses the discussion on BMI with, "Now this is the body mass index, and we, again, don't want it to get above the 85th, and you're right at the 85th." The care provider again emphasizes that the child is at the 85th percentile mark for BMI, the cut off for overweight status according to clinical guidlines.[35] No identity label is provided. Instead, the care provider emphasizes that the child must keep his weight below the 85th percentile mark.

The care provider continues within the same utterance, "So this is why your mom and I are talking about" (lines 13-14). The mother completes the sentence with, "Exercising." (line 15). Here the mother's interruption functions as a *pre-emptive completion*, in which "the recipient responds to a prior speaker, not by waiting until the completion to act, but by pre-empting that completion as a method of responding". [59(p225)] Here both the care provider and mother use the information from the growth chart and BMI to promote a particular action step. Notably, the child's weight status is not tied to an overt identity, as it was in the treatment of normal weight children. Rather the care provider uses the information from the growth chart and BMI as a call to action, in this case, exercise.

“it just took off”

The excerpt below, with a 7-year-old boy, provides another example of a care provider delivering the growth chart information without applying an identity label:

2) Pediatrics 33.4

1	Care Provider:		Okay. Gotcha, gotcha. Well, okay. Um, so, let’s get back to what you had
2			mentioned, a little bit about weight. So, you can see it was kind of just these last,
3			oh, three years was always along right along in here
4	Dad:		[Umhuh]
5	Care Provider		at the line, and then …
6	Dad:	→	**And he’s climbing**.
7	Care Provider:	→	**Boom**. Well, and then, **at this rate, then he’ll be up there**. So, here’s your
8			height, how tall you are. He’s right staying right along here where he’s always
9			been.
10	Dad:		It’s a pretty good line.
11	Care Provider:		Okay. Um and that’s where his weight was.
12	Dad:		[Umm]
13	Care Provider:	→	But you can see now – oh, it was along here, but then at around age six, **it just**
14			**took off.**
15	Dad:		Umhuh
16	Care Provider:		So, think anything has changed a lot in the last three years? In terms of more
17			sedentary?

In line 1, the care provider directs the conversation to the child’s weight with, “Well, okay. Um, so, let’s get back to what you had mentioned, a little bit about weight.” Here the term “okay” is used to transition the conversation away from previous topics and towards the child’s weight. Previous research[39] exploring the use of “okay” in conversations has found that, “*Okay* usages not only work to initiate closure for some prior actions, but in so doing make possible and thus project continuation toward some next matters”.[(p146)] In this instance, the conversation is transitioned away from previous discussions to address the son’s weight. Earlier in the well-child visit the dad mentioned that his son had been gaining weight. Specifically, the dad commented that the son was “gaining a little bit too much weight right now, I think.” (not included above).

The care provider addresses the father's previously mentioned concern by turning to the growth chart. In line 2, the care provider continues, "So, you can see it was kind of just these last, oh, three years was always along right along in here." The care provider refers to the son's weight on the growth chart as "it" and shows the dad how the son's weight had been progressing, establishing where it had been for the past three years. The dad nonverbally agrees with "Umhuh" in overlap (line 4) as the care provider continues, with "at the line and then…" (line 5). Here the care provider marks the son's rate of growth as changing.

In line 6, the dad finishes the care provider's statement himself with "and he's climbing." In this way, the dad notes that his son's weight has climbed from where it has been in past 3 years. The care provider dramatically states: Boom." (line 7). The care provider's statement emphasizes that the son's weight has indeed climbed at an unhealthy rate. The care provider continues, "Well, and then, at this rate, then he'll be up there." (line 7). In line 7, the care provider again turns to the growth chart to contrast the son's gain in height (e.g., "staying right along here where he's always been" lines 8-9) with his gain in weight (e.g., "But you can see now – oh, it was along here, but then at around age six, it just took off" lines 13-14). In this way, the care provider notes that the son's height has increased at the same rate while his weight recently "took off." By contrasting the growth in height with the growth in weight, the care provider indirectly marks the growth in weight as problematic as compared to height.

Throughout this interchange, the dad and care provider work together to argue for the son's unhealthy weight gain. The dad provides response tokens[60] like "Umhuh" (line 4), "Umm" (line 12), and "Umhuh" (line 15) to indicate he is hearing the care provider and encourage the care provider to continue. In a sense, the dad and care provider work together to tell the story about the son's weight gain. Despite the dramatic language (i.e., "boom" and "took off"), at no

point does the care provider directly label the son as overweight or obese. In fact, in visits with normal weight patients, weight-based identity labels were typically provided immediately after delivering the growth chart information to both reassure the parents and children as well as communicate the bottom-line meaning of the child's health status (see Chapter 3). Here the care provider does not provide an identity label. The child's weight status is not used to label his identity or communicate a bottom-line meaning of the growth chart and BMI information. The care provider cannot reassure the parents of their child's health status, simply because such reassurance would not be accurate. Furthermore, using an overweight identity label risks being insensitive and even stigmatizing.[44] As such, the care provider here is careful to avoid labeling and instead moves from the assessment of the child's weight to an assessment of the child's behavior and the promotion of specific action steps in lines 16-17.

The above two excerpts highlight the differences between how care provides communicate about weight and weight status with overweight/obese patients as compared to normal weight patients. These findings confirm previous quantitative research, which found that student care providers dis-preferred overt labels, like obesity, and instead preferred terms like "unhealthy BMI".[58] The care providers here also appear to avoid overt labels, like "obesity" or "heavy," and instead direct the parent and child's attention to the growth chart.

The lack of weight-based labeling with overweight/obese patients is subtle but not insignificant. It marks these interactions as more delicate, likely because of the potential for stigma or imputation of blame.[8,44] The lack of weight-based labeling also marks a change in the level of subtlety used with overweight/obese patients as compared to normal weight patients and elucidates the care provider's management of a precarious balance. On the one hand an overt and clear mention of overweight/obese status risks offending the parent and child,[8] damaging the care

provider-patient rapport, and could even negatively impact the child's self-image. In fact, previous research of parents' perceptions of weight-based terms, found that parents reported overt weight terminology (i.e., obese), the most stigmatizing and blame-inducing and the least motivating for weight loss.[8] Nonetheless, on the other hand, too much subtlety risks not communicating the overweight/obese status sufficiently, leaving parents and children either unaware that the child is overweight/obese or uninformed about the clinical significance of the child's weight status.[61] A basic argument can be made that the care providers must clearly inform the parent and child about the child's weight status, yet do so as delicately and humanely as possible. A further layer of this subtlety is revealed and examined below.

Excessive Abstraction

In well-child visits with overweight/obese patients care providers appear to use excessively vague language when reviewing the growth charts and delivering the news of the child's overweight or obese status. Rather than overtly communicating the child's weight status as overweight or obese, care providers indirectly refer to the child's weight status. This includes using language that partially or even fully removes the child from the overweight or obese status. I have termed this behavior *excessive abstraction.* Excessive abstraction occurs when care providers use a pronounced degree of subtlety when discussing the child's overweight or obese status. Care provider's use of subtlety when communicating overweight or obese status is not surprising given that previous research has indicated that care providers may dis-prefer overt terms, like obesity, in favor of euphemisms.[58] However, the use of extreme subtlety risks obscuring the communication of the child's weight status, a weight status that must be clearly communicated to parents and children. Additionally, when the child's weight status is not clearly communicated during the discussion of the growth chart and BMI, the care provider may use

other tactics to communicate the child's weight status, and these tactics may be problematic or stigmatizing in their own right (explored in a later section).

"So it wasn't going up as fast as it was"

In the following excerpt, the care provider is discussing the results of the growth chart with an obese 11-year-old boy and his mother. The care provider and mother have just finished discussing the son's high blood pressure. Now the care provider presents the findings of the growth chart:

3) Pediatrics 9.12

1	Care Provider:	→ Let's see. So here's his growth chart. Okay. Coming up this way. So **it** wasn't
2		going up as fast as **it** was.
3	Mom:	Mm-hm.
4	Care Provider:	→ **The the rate** has slowed down a little bit, so that's good. And length, still getting
5		taller. Staying up at that 75th percentile. We've done this with you guys? We
6		haven't. How tall are you?
7	Mom:	5'7".
8	Care Provider:	And how tall is dad?
9	Mom:	Hmm. Let's go with 5'9".
10	Care Provider:	5'9"?
11	Mom:	5'8".
12	Care Provider:	5'8".
13	Mom:	5'8. Somewhere in there.
14	Care Provider:	Well, uh so we we put mom and dad's heights in here, and for um, and for boys–
15		you average them, and for boys you then add two or three inches, girls, you
16		subtract two or three inches, to see how tall you might be. And we'll put that
17		in here, and this says –You're gonna be taller than mom!

In line 1, the care provider directs the conversation to the growth chart and notes the child's rate of growth as an "it," with "Coming up this way. So **it** wasn't going up as fast as **it** was." (lines 1-2). Notably, the child is in the 98th percentile for weight, which places him in the obese category.[35] However, when delivering the results of the growth chart the care provider does not overtly mention the child's obese status. Instead, the child's weight is referenced as an, "it"—an entity separate from the child and one that, in fact, can be viewed by the parent and child from a distance (lines 1-2). This language removes the child's weight from the child. Similarly, the

child's weight is also addressed as a rate of growth with, "**The the rate** has slowed down a little bit" (line 4). Once again, the child is removed from his weight and is instead viewing the results as a "rate" (line 4) that can be assessed and improved and is not tied to his identity or person. The decline in weight gain, though trending in the right direction, still does not appear to be going quickly as it has "slowed down a little bit" (line 4). Nonetheless, the care provider evaluates and marks the decline in weight gain as favorable with, "so that's good." (line 4). In the remainder of the growth chart discussion, lines 5-17, the care provider, mother, and child discuss the child's height, using the parents' heights to project the son's adult height. No further overt mention is made of the child's weight or obese status.

The care provider here treats the patient kindly and warmly. The child is included in the discussion, and no stigmatizing or hurtful labels or language are used. In including the child [53] and using non-stigmatizing language,[8] the care provider builds and fosters a positive relationship with the parent and child. However, the discussion of the growth chart and results of the child's weight status are abstract to the point of obscurity. The child's weight is completely removed from the child and referenced as a separate entity—an "it," or "rate," that can be viewed from the parent and child as if they were outside of it. Here, the care provider does not overtly communicate the child's weight status or relay a diagnosis. The child is commended for a declining rate of weight gain, but the child's high weight status is not fully addressed and only briefly referred to as "it," or "the rate," before quickly re-directing the discussion to the child's height. For an obese patient, *such excessive abstraction may make it difficult for the parent and child to understand that the child's weight is truly a problem in need of clinical attention*.

"stay there or under"

The excerpt below includes a well-child visit with an overweight 9-year-old girl:

4) Pediatrics 11.29*

1	Care Provider 3:→	**She kind of juggles up and down.**
2	Mom:	Yeah.
3	Care Provider 3:→	**So we'd like for her to stay there or under.**
4	Mom:	-I think she's on the precipice of puberty.
5	Care Provider 3:	[in overlap] She's right at the..
6	Child 1:	[in overlap] Well, how big am I?
7	Mom:	I think we're getting to that age of-
8	Care provider 3:	All right.

The care provider notes that the daughter's weight, "kind of juggles up and down" (line 1). The mom aligns herself with this assessment with "Yeah" (line 2). Rather than overtly labeling the daughter's overweight status, the care provider abstractly refers to the daughter's growth with, "So, we'd like for her to stay there or under" (line 3). Notably, the care provider does not completely remove the child from her weight (as was done in excerpt 3). However, akin to excerpt 3 above, the daughter's weight status is referred to as if it were a location, with "stay there or under," (line 3) rather than a diagnosis.

The mom, although aligning herself with the care provider's assessment in line 3, puts forth a candidate explanation for the vaguely referred to overweight status with, "I think she's on the precipice of puberty" (line 4). As the mom is mentioning this explanation, the care provider in overlap starts to explain that the daughter is "right at the" (line 5) but doesn't finish with a full explanation of where the daughter is on the growth chart, at least not verbally. The child seems confused by this abstraction and asks in overlap, "how big am I?" (line 6). The child's question indicates that the discussion about her weight (see: lines 1-3) was not sufficient to communicate her weight status to her, and she remains unclear about her growth or overall weight status. Thus, in this well-child visit, the excessive abstraction appears to confuse rather than communicate the weight-status to the daughter.

“same rate as it did last year”

Similarly, in the subsequent well-child visit with a 10-year old boy who is approaching overweight (a longer version of this same excerpt appeared above in excerpt 1), the care provider discusses the child’s weight in extremely abstract terms:

5) Pediatrics 10.16 (also used above)

1 Care Provider: → Okay. So as you're going along, **your weight** has gone up, but at about the same
2 rate as **it** did last year. **It's** the same place on the chart, I should say. So at about
3 → the- almost the 85th percentile. **We don't like it to** get above that, okay? So let's
4 look at your length. And it is about the 75th percentile. So you're pretty tall as
5 → well. Now this is the body mass index, and we, again, **don't want it to get above**
6 **the 85th,** and you’re right at the 85th. So this is why your mom and I are
7 talking about –

In line 1, the care provider begins by discussing the child’s weight as a rate of growth with, “So. As you’re going along, your weight has gone up, but at about the same rate as it did last year.” Here the care provider does not completely remove the child from his weight as the care provider states, “your weight” (line 1), linking the child to his weight. However, as the visit continues the child’s weight is consistently removed from the child and discussed in the abstract. For example, in line 2, the care provider references the child’s weight as “it” and continues with, “It’s the same place on the chart, I should say.” Similarly, when the care provider notes that the child’s weight may be problem, the child’s weight is again referenced as an “it” rather than a you, with, “So at about the—almost the 85th percentile. We don’t like it to get above that okay?” (lines 2-3). In this way, the care provider addresses the child’s weight by pointing that “it” is almost at the 85th percentile and should not exceed that location. In so doing, the care provider notes that the child’s weight might be a clinical concern, which involves keeping a separate entity, “it”, below a certain point, “85th” percentile.

Similarly, in line 5, when the care provider addresses the child’s BMI, the child’s BMI is again referenced as an “it” with, “Now this is the body mass index, and we, again, don’t want it

to get above the 85th, and you're right at the 85th." (line 6). This is the 4th time the care provider has abstractly referred to the child's weight as "it" (see lines 2, 3, and 5). This excerpt illustrates the tendency for care providers to remove the negative and potentially stigmatizing[44] discussion of overweight as far from the child and parents possible, instead locating the problem as an "it" that can be addressed and improved and must stay below a certain percentile on the growth chart. The care provider's use of "it" (in lines 2, 3, and 5) to abstractly reference the child's weight is nearly identical to the use of "it" in excerpt 3 (above). In excerpt 3, the care provider describes and addresses the child's weight with, "So it wasn't going up as fast as it was" (excerpt 3, lines 1-2). The similarity in the care provider use of "it" in both excerpt 3 and excerpt 5, points to how the term "it" is utilized to indicate the child's weight in the most abstract terms possible.

In summary, care providers appear reticent to overtly communicate the child's overweight or obese status and instead vaguely refer to the child's weight status as a location on the growth chart (see excerpts 3, 4 and 5) or rate of growth (see excerpts 3, 4, and 5) that is oftentimes completely separated from the child. Care providers' abstracting of the child's weight status indicates delicacy and careful consideration, as well as awareness, for the potential of weight stigma and blame associated with a child's overweight or obese status.[8,61,62] However, if the child's weight is consistently discussed outside of the child, it may be difficult for the parent and child to take ownership of the child's health, or even fully understand that there is an issue worthy of attention.[61] One of the potential problems with a euphemistic communication about overweight or obese status is that it may impede the parents' full understanding of their child's weight. Previous qualitative research with preschool-aged children and their parents and grandparents revealed that knowledge of the child's growth chart and growth percentiles did not necessarily translate into an understanding of their child's overweight or obese status.[61]

Presenting growth chart information may not be enough for parents to understand that the child is overweight or obese. Thus, abstractly referring to a child's weight status as a location on the growth chart or rate or growth (see excerpts: 3-5) may be insufficient. Alternatively, some parents may correctly interpret the care provider's indirect language and fully understand their child's high weight status, while accepting that the child's weight be discussed in abstract terms.

Nonetheless, the use of excessive abstraction when discussing the child's weight may place the burden on care providers to use alternative strategies to communicate the child's weight status. These alternative strategies may be potentially stigmatizing and problematic in their own right. One such strategy is discussed below.

Extensive and Potentially Stigmatizing Behavioral Counseling

As discussed in Chapter 3, in well-child visits with normal weight patients, care providers take inventory of the child's eating habits and sometimes briefly mention physical activity. Rarely do care providers move beyond simply taking inventory of the child's eating and exercise behaviors. In contrast, in well-child visits with approaching overweight, overweight, and obese patients, care providers move beyond merely taking inventory of diet and physical activity and instead engage in extensive and potentially stigmatizing behavioral counseling about diet and physical activity.

In these well-child visits, care providers appear to use targeted behavioral counseling to indirectly communicate the child's weight status to the parent and child. However, this intense emphasis on behavioral counseling is framed to imply that the full responsibility of the child's overweight and obese status is on parent and child behavior. In so doing, care providers allow the child's weight status to "spoil" the child and parent's identity and thus "impute a wide range of imperfections on the basis of the original one."[44(p5)] Specifically, by focusing almost exclusively

on individual behavior to address and communicate weight status, care providers indicate a belief that higher weight must denote misbehavior. Not only is this approach to overweight and obese status stigmatizing to the parent and child, but it also limits potential treatment to individual behaviors alone (e.g., diet and physical activity), while neglecting to address alternative explanations or solutions like environmental factors or genetics.[62]

As previously explained, care providers in the examined well-child visits approach overweight/obese patients by a) avoiding weight-based labels and b) only abstractly and euphemistically reference the child's weight. Both fall short of clearly communicating weight status. To indirectly communicate the child's weight status, and mitigate the potential ambiguity from excessive abstraction, care providers use targeted counseling on diet and physical activity. Specifically, care providers focus the discussion on assessing and improving diet and physical activity (further examined in the excerpts below).

"So, you really want to look at the places that we can…umm – it's tough"

The excerpt below with a mother and her 7-year-old daughter provides an example of how behavioral counseling is used by care providers to indirectly communicate weight status in lieu of a clear and overt discussion of weight. The length of this excerpt is necessary to situate how indirectness is accomplished.

6) Pediatrics 36.4

1	Care Provider:		Okay. What do you eat for snacks?
2	Child:		Uuuh. Well, mostly when I have snacks, I either have them at school or at home,
3			but [laughs]I never know which snack. It's always different at school, so. But
4			mostly at home, I have a bar.
5	Mom:		Oh, like a Z bar.
6	Child:		Yeah.
7	Mom:	→	Do you know what that is? Um, that is one of the challenges. So, she's in, she's
8			in an afterschool program, and they have snacks,
9	Care Provider:		Mm-hm.
10	Mom:		Which is like almost a whole meal in the middle of the afternoon. So, it'll be a
11			whole other like, yeah, a turkey sandwich on a white roll with a yogurt and an

12 apple and all of that, and I don't –
13 Care Provider: [in overlap] Yeah.
14 Child: I never eat the turkey sandwich.
15 Mom: You don't, yeah.
16 Child: Uh-uh.
17 Care Provider: → -Yeah. But I think like, you know, when we look at her… growth, I'm gonna
18 show you. So, let's look at her body mass index. So, this is what her body mass
19 index is at.
20 Mom: Mm-hm.
21 Care Provider: → So, everything above the 95th percentile, as you know, is here… **So, you really**
22 **want to look at the places that we can…umm – it's tough.** Yeah. So like
23 things like having a granola bar, a Z bar, those things have a lot of sugar in them.
24 Mom: Yeah.
25 Care Provider: And so, choosing something maybe like pretzels or, you know
26 it's still carbohydrates
27 Mom: Mm-hm
28 Care Provider: Umm, but reduces the amount of sugar, especially if you're kind of battling this
29 after school snack.
30 Mom: [in overlap] Mm-hm. Mm-hm
31 Care provider: But depending on what she chooses, it might be just fine
32 Mom: Mm-hm.
33 Care Provider: Because there are so many outside influences, and including 50 percent
34 of the time, having no control over.
35 Mom: [in overlap] Mm-hm. Mm-hm.
36 Care Provider: And you're gonna try to make your.. what you give as healthy as possible.
37 Mom: Right
38 Care Provider: And kind of as whole as possible.
39 Mom: Right
40 Care Provider: So, it'd be better for her to have like grapes and raspberries and turkey meatballs.
41 Mom: [in overlap] Yeah. Yeah.
42 Care Provider: Trying to –uhh you know…and
43 Mom: -Less processed.

[1 minute and 33 seconds later in the same visit the care provider and the mom are talking about exercise]

44 Mom: -But that may change, is what you're saying?
45 Care Provider: → -But, um, I think lik**e focusing, yeah, but like, really trying to keep her same**
46 **weight**
47 Mom: Mm-hmm
48 Care Provider: Umm as she continues to grow.
49 Mom: [in overlap] While she grows taller, yeah.
50 Care Provider: And so, that's gonna be the aim, not weight loss.
51 Mom: Mm-hmm
52 Care Provider: Just staying. And so, I would completely take the juice.
53 Mom: Kay.
54 Care Provider: → Um and then focusing on, you know, limiting, looking at a granola bar, Z bar,
55 those are basically like a treat
56 Mom: Yeah.
57 Care Provider: A dessert.
58 Mom: Mm-kay.

59	Care Provider:	Umm and limiting the desserts to once or twice a week.
60	Mom:	Mm-hmm.

In the above excerpt, the care provider discusses the daughter's eating habits with the mother and daughter. Specifically, the care provider, child, and mother discuss the topic of snacks (lines 1-16). During this interchange, the mother initiates a concern that her daughter's afterschool program includes a large snack (lines 7-8; 10-12). In response to the mother's concern about the child's eating, the care provider turns to the growth chart, introducing the topic in line 17 with, "-Yeah. But I think like, you know, when we look at her… growth, I'm gonna show you. So, let's look at her body mass index. So, this is what her body mass index is at.". The care provider attempts to explain the body mass index by showing where the 95th percentile is with, "So, everything above the 95th percentile, as you know, is here" (line 21).

Rather than overtly informing the mother and daughter about how the information from the daughter's growth chart pertains to her overall weight status and potential implication for the daughter, the care provider immediately jumps to behavioral counseling, with, "So, you really want to look at the places that we can…ummm – it's tough. Yeah. So, things like having a granola bar a Z bar, those things have a lot of sugar in them." (lines 21-23). In jumping from the growth chart results (lines 17-19; 21) to behavioral counseling (lines 21-23), the care provider skips the steps of test result reporting (i.e., growth chart and BMI) and diagnosis (i.e., overweight or obese) and moves straight to treatment, in this case, eating behavior modifications. The mother and child are not clearly informed about the child's weight status. Instead, the care provider leaps to behavioral counseling. Notably, this leap is halting. The care provider interrupts herself and states, "it's tough." (line 22). The food and exercise counseling continues from lines 22-43. The mother provides response tokens[60] throughout (i.e., "Mm-hmm," "Right") and even

interrupts the care provider in line 43, indicating alignment with the care provider's position and co-creation of the narrative[63] that her daughter's diet could be improved.

Later in the visit, after the mother and care provider discuss exercise, the care provider overtly mentions the daughter's weight with, "But, um, I think like focusing, yeah, but like, really trying to keep her same weight" and continuing "Umm as she continues to grow." (lines 45-46; 48). This is the first overt mention of the daughter's weight, and even this mention is abstract to the point of confusion. The mother clarifies in line 49, "While she continues to grow taller. Yeah." The care provider again immediately turns to behavioral modification with, "And so, I would completely take the juice." (line 52). The care provider also mentions limiting sugary foods like granola bars to once a week (lines 54-55;57;59).

This excerpt provides a clear example of the interaction between excessive abstraction and behavioral counseling. In lieu of overt mentions of weight and weight-based labels, care providers turn to behavioral counseling to tacitly imply overweight or obese weight status, rather than overtly mentioning it. The potential problem is that parents and children are less clearly informed of weight status. Additionally, by using a discussion of behavior to communicate the child's weight status, the care provider tacitly implies that the cause, and by implication, the blame for the child's weight status lies with parent and child behavior, potentially neglecting additional causes and further stigmatizing[62] the parent and child.

"So, think anything has changed a lot in the last three years"

Excerpt 7 involves a 7-year-old boy and his mom, dad, and older sister.

7) Pediatrics 33.4 (continuation of excerpt from earlier section)

1 Care Provider: Okay. Um and that's where his weight was.
2 Dad: [Umm]
3 Care Provider: But you can see now – oh, it was along here, but then at around age six, it just
4 took off.
5 Dad: Umhuh

6 Care Provider: → So, **think anything has changed a lot in the last three years? In terms of**
7 **More sedentary?**
8 Dad: → Well, you know, his **eating habits have changed**.
9 Care Provider: Mm-hm.
10 Dad: You know. He's, I mean, he eats like macaroni and cheese and pizza.
11 Care Provider: Mm-hm.
12 Dad: → You know. And and **I'll make him, you know, eat the chicken.**
13 Child 2: Chicken nuggets.
14 Care Provider: Mm-hm.
15 Dad: And I'll do like breakfast. I'll, I mean, I've done different things like getting hot
16 pockets with scrambled eggs and sausage.
17 Care Provider: Right.
18 Dad: You know, the bacon ones. Just pancakes, a little bit. We're trying not to give
19 him too many starches like that. You know.
20 Care Provider: → Right. So, mostly **it's it's not it's it's the food, it's the amount, typically, for**
21 **people.**
22 Dad: Yeah.
23 Care Provider: The volume.
24 Dad: -Yeah, sometimes it's the volume. Like I made a box of macaroni and cheese,
25 and he can eat the whole thing by himself.
26 Care Provider: Right, so that's so that's the point.
27 Dad: Yeah, that's you know
28 Care Provider: [in overlap] Is that it's not…
29 Dad -And then when he asks me for seconds because he's still hungry, that's because
30 I'm not hungry here. I'm not hungry there. And then when he gets gets hungry he
31 thinks he has to eat the whole thing. You know. Like bagels, he'll eat like three
32 bagels if you let him.
33 Care Provider: → Right. So, part of that is some **some restriction**.
34 Dad: Right, exactly.
35 Care Provider: → -Okay. Part of that is then **replacement** in regards to then um um fruits,
36 vegetables, water.

Lines 1-7 (examined in a previous section) include the care provider carefully addressing the child's weight gain. As mentioned previously, there is a subtly here. At no point during this interchange does the care provider directly label the child's weight status. Rather, the child's weight is discussed with abstraction. The child's weight is framed as an "it" (line 3) that "took off" (line 4) and thus is removed from the child (for a full discussion and analysis of lines 1-7 see excerpt 2).

Up until this point, the care provider has not fully and clearly communicated the child's weight status. Instead, to mark the child's weight as clinically important, the care provider

focuses the discussion on the child's eating and exercise behaviors, beginning with a question about exercise: "So, think anything has changed a lot in the last three years? In terms of more sedentary?" (lines 6-7). The care provider's question in lines 6-7 requests an account for how the child's behavior might explain his spike in weight, without directly asking about weight. The question assumes, and implies, that the spike in weight can be accounted for by a "change" (line 6) in the child's exercise behavior.

Rather than answering the care provider's question about physical activity the dad initiates a comment about his son's diet with, "Well, you know, his eating habits have changed." (line 8). Here the dad acknowledges and accepts the child's gain in weight can be accounted for by behavior but shifts the topic of behavior to diet rather than exercise. The dad continues to detail his son's eating (line 10) and frames himself as encouraging his son toward healthy choices with, "You know. And and I'll make him, you know, eat the chicken." (line 12). The teen daughter elaborates and somewhat diminishes her father's claim as health advocate by qualifying the chicken as, "Chicken nuggets" (line 13).

In the lines that follow (lines 14-36) the care provider continues to counsel the dad on the child's diet, and the dad continues to agree and provide confirming stories. Specifically, the care provider counsels the dad to reduce the amount of food the son is eating (lines 20-21; 23), to implement restriction (line 33), and replace unhealthy foods with healthier foods (lines 35-36). Throughout these lines (lines 1-34), the dad and care provider work together to treat the son's weight as clinically relevant and in need of behavior change, in this case, the modification of eating behavior. At no point is the son's weight status overtly provided. Rather the specifics of his growth chart and BMI are followed with a targeted discussion of diet change, indirectly communicating that his weight status is clinically relevant. Furthermore, diet and physical

activity are the only potential causes for the weight gain discussed by the dad and care provider. Additional possible causes, such as genetics, environment, or other mental or emotional factors are not addressed or considered.

Similar to excerpt 6, in excerpt 7 the care provider uses targeted behavioral counseling to: a) indirectly communicate the child's weight status, and b) mitigate the potential ambiguity from excessive abstraction. Rather than overtly discussing the child's weight status after BMI and growth chart results, the care providers in both well-child visits skip directly to behavioral counseling. Unfortunately, using behavioral counseling to communicate weight status is not without cost. One such cost is discussed in the subsequent section.

"Be careful about sweet drinks and extra helpings"

The subsequent well-child visit, with an overweight 9-year-old girl, provides an example of how behavioral counseling can frame the child's weight status as resulting from indulgent behavior:

8) Pediatrics 11.34*

1	Care Provider 3:	All right. So. Growth we've already looked at. So just encouraging good healthy
2	→	diet choices, all right? **Be careful about sweet drinks and extra helpings at**
3		**meal times.**

As discussed above, rather than providing a weight-based label or overtly discussing the child's obese status, the care provider moves immediately to behavioral recommendations with, "So just encouraging good healthy diet choices, all right?" The child does not respond. The care provider continues, "Be careful about sweet drinks and extra helping at meal times" (lines 2-3). Here the care provider appears to oversimplify the potential causes and treatments for overweight and obesity and indicates that a weight-problem could be fixed by simply limiting sweet drinks and not having seconds.

“not too much ice cream”

Similarly, the care provider also assumes indulgent eating behavior in the well-child visit below, with a 10-year-old boy who is approaching the 85th percentile for weight:

9) Pediatrics 10.16

1	Care Provider:		Now this is the body mass index, and we, again, don't want it to get above the
2			85th, and you’re right at the 85th. So, this is why your mom and I are talking
3			about –
4	Mom:		Exercising.
5	Care Provider:	→	**Making good choices when you’re eating and not too much ice cream and all**
6			**of those fruits and vegetables that are important, okay?**
7	Child:		Exercising, Exercising [softly, in overlap]
8	Mom:		More fruits and vegetables [in overlap]
9	Care Provider:		And, again, last year, you were a little lower. So this is just a reminder. You
10			were back here, when you were four, you were up here, you dipped down, and
11		→	then you went back up. **So now is the time for us to get serious about the**
12			**exercise. Okay?** So if you can climb up here for me.
13	Mom:		We were just talking about what to do on this weekend and on Friday
14	Care Provider:		Right.
15	Mom:		Bike riding came up in the mix
16	Care Provider:		Okay. Good. Good. Hoping that the weather's nicer–
17	Mom:		Yeah.
18	Care Provider:		Yeah.
19	Child:		Wait, when do we get to go bike riding?
20	Mom:		Maybe this weekend.
21	Child:		Cool.
22	Care Provider:	→	Why don't you put your legs over the edge here?– **I know last year there were**
23			**changes in your family with your mom and dad, two different houses. How**
24			**are you doing with that now?**
25	Child:		Um, I'm kind of used to it.
26	Care Provider:		You're kind of used to it? Counselor?

Immediately after reviewing the specifics of the growth chart and BMI, the care provider comments, “So, this is why your mom and I are talking about.” (lines 2-3). In overlap, the mom continues the care provider’s sentence and states, “Exercising.” (line 4). By finishing the care provider’s statement, the mom aligns herself with the care provider’s emphasis on behavior change and, additionally, supplies what this change should include—exercise. In this way, the mom and care provider work together to argue that specific behavioral modifications are needed to address the son’s high weight, which is “right at the 85th” percentile (line 2).

The care provider clarifies the mother's statement and switches the focus from exercise to eating behavior with, "Making good choices when you're eating and not too much ice cream and all of those fruits and vegetables that are important, okay?" (lines 5-6). Here the care provider frames the son's weight gain as directly addressed by "not too much ice cream." The care provider's words oversimplify the role of eating with weight management, implying that the son's current weight gain is a result of indulgence, the correction of which not eating a "too much ice cream" is projected to solve. The care provider ends the statement by requesting acknowledgment from the child with, "okay?" (line 6). The "okay" (line 6) functions as a *tag-positioned okay*, used by the speaker to request understanding or compliance.[39] The child does not provide this acknowledgement. Moreover, while the care provider is talking in lines 5-6, the child softly repeats "Exercising, Exercising" (line 7) quietly to himself—indicating that perhaps he is not fully engaged with the care provider's words as he is still echoing the words of his mother from line 4.

The care provider continues with, "And, again, last year you were a little lower" (line 9). The care provider's *and-prefacing* (line 9) indicates that the statement to follow will be a continuation of the argument made earlier [64]—that the child's weight is growing and in need of behavioral change. The care provider continues, "So this is just a reminder. You were back here, when you were four, you were up here, you dipped down, and then you went back up. So now is the time for us to get serious about the exercise." (lines 9-12). With these statements, the care provider thoroughly discusses the child's growth chart history, noting that his weight was high (when he was four), went down, and then has now increased. These statements are immediately followed by a re-emphasis of exercise, with the emphatic statement, "So, now is the time for us to get serious about the exercise. Okay?" (lines 11-12). The care provider uses extreme language

here (i.e., "get serious about the exercise", lines 11-12) marking exercise as worthy of somber attention. Once again, the care provider delivers the results of the child's weight gain, in tangent with a recommendation for behavioral change, and in so doing, implies that the parent and child's mis-management of eating and exercise is also the cause of the weight gain.[62] Again, the child does not respond to the care provider's "Okay?"(line 12). However, the mother aligns herself with the care provider's recommendation, by describing a plan to exercise with the child, specifically bike riding in the coming weekend (lines 15-21). In this way, the care provider's attempts to convince the mother and child of the need for behavioral changes has been successful with the mother—at least in the care provider's office.

While performing the physical exam the care provider inquires about the child's experience with his parent's separation, asking: "I know last year there were changes in your family with your mom and dad, two different houses. How are you doing with that now?" (lines 22-24). The child responds with, "Um, I'm kind of used to it." (line 25). Despite the care provider's attention to the child's experience of his parent's separation, the possible link of the child's weight gain with his parents' separation is not fully explored or addressed in the subsequent discussion. Indeed, it seems worthy of consideration that the child's weight has increased to the point of overweight status in the same year that his parents have separated. However, the link of the child's weight gain with his parent's separation is not fully explored. Rather, the full burden of the child's weight gain is placed on eating and exercise. And this potential root cause is left unexamined.

Overt weight discussions appear to be replaced with targeted discussions of diet and physical activity. These targeted discussions may seem, at first glance, as a compassionate and subtle way to communicate weight status. Indeed, the care providers in the sampled well-child

visits attempt to use these discussions as such. Nonetheless, moving directly from BMI and growth chart results to intense behavioral counseling communicates more than subtlety. This approach implies blame—specifically, weight-based stigma and the spoiled social identity.[44] The care providers' use of intense behavioral counseling in the sampled well-child visits exhibits aspects of weight-based stigma, in that, child and parent behavior are framed as the main cause, and thus the solution for the child's weight status. This is especially noteworthy because parents of obese or overweight children may already feel stigmatized and/or blamed by care providers and society.[61,62]

Chapter Summary

As depicted in Figure 5, this chapter elucidated several key findings for care provider, parent, and child communication about weight, diet, and physical activity with overweight/obese child patients:

First, care providers do not provide weight-based labels for overweight/obese patients. Information from the growth chart and BMI is not tied to child identity and is not used to reassure. The potential drawback of this approach is that parents are not clearly informed of their child's weight status. Additionally, previous research has indicated that BMI information is not sufficient to communicate a child's weight-status to parents.[58]

Second, care providers seem to apply a further layer of euphemism and engage in a behavior, here termed, *excessive abstraction*, when discussing the child's weight. This includes using language that partially or even fully removes the child from the overweight or obese weight status. For overweight/obese patients, such excessive abstraction may make it difficult for the parent and child to understand that the child's weight is truly a problem in need of clinical attention.

Third, in lieu of a clear communication of weight status, care providers supplement with extensive and potentially stigmatizing[44,62] behavioral counseling about diet, physical activity, and weight. This is used to indirectly communicate weight status. By immediately focusing on and framing current behavior as indulgent (i.e., "not too much ice cream" see excerpt 9), the care provider may inadvertently imply blame and underline existing feelings of weight-related shame or stigma for both the parent and child. Weight-stigma has detrimental consequences for both individual health and public health, including reduced health care utilization, psychological disorders, unhealthy eating, and lower physical activity.[62]

Finally, care providers in the sampled well-child visits focus almost exclusively on diet and physical activity as the cause and solution for weight management. In these well-child visits the main treatment appears to be encouraging parents and children to eat and exercise better. Previous research indicates that lifestyle interventions with a dietary component decreased the weight of overweight and obese children.[65] However, this research focused only on effects up to 1 year from baseline.[65] It is unknown if the children were able to maintain their weight-loss over time. Additionally, a recent meta-analysis examining physical activity interventions with overweight and obese children found that these interventions have had no impact, and have not increased total physical activity either post-intervention or long-term.[66] Although diet and physical activity may be important for weight loss, they are not the only factors to consider, and physical activity may be difficult to modify.[66] An exclusive focus on eating and exercise behavior neglects a proper accounting for environmental, societal, familial, and genetic causes of high-weight status, and the potential avenues for intervention that these provide.[62]

Furthermore, in focusing solely on eating and exercise behavior, care providers may neglect to fully examine other potential, and perhaps more root, causes of weight gain, and

overweight/obese status, such as parental separation (see excerpt 9) or other behavioral factors. These causes may drive excessive and unhealthy eating behavior. Addressing these could provide a more lasting solution. During well-child visits, care providers could subtly assess more root cause issues like possible adverse childhood experiences, particularly if these are brought up during the course of the well-child visit, to explore how or if these impact the child's eating or other self-care behaviors. Further work would need to determine how to do so in a way that protects the safety of the child, especially if the disclosure negatively portrays the parent.

Link to Quantitative Findings

The findings from the current chapter help to more fully explain the findings from Chapter 2, which presents the quantitative findings for the current research project. The findings from Chapter 2 also contextualize the findings in the current chapter. As discussed in Chapter 2, parents with children of all weights reported high satisfaction with care provider communication about weight diet and physical activity (as measured by the P-MISS-CWDPA). Specifically, median scores were extremely high for all items on the P-MISS-CWDPA scale with 16 of the 17 items having a median score of 7 out of 7. This indicates a high overall satisfaction with care provider communication about weight, diet, and physical activity. These quantitative findings, taken together, seem to indicate that parents, in general, were highly satisfied with care provider communication about weight. This finding is worthy of discussion given that care providers used excessive abstraction and intense and potentially stigmatizing behavioral counseling with parents and children. Although the sample was too small to allow for specific quantitative examination of communication satisfaction by weight group (i.e., underweight, overweight/obese), these findings do indicate that parents of higher BMI children were not excessively displeased with care provider communication. This might be because care providers in this sample were quite

delicate in their treatment of weight by avoiding weight-based labels, using excessive abstraction, and communicating weight status indirectly with behavioral counseling. Although these communication behaviors may have room for improvement, the finding that parents of children of all weights reported high approval indicates that even parents of higher weight children perceived their experience as positive overall.

The high parent satisfaction rating in tangent with the concerning qualitative findings, highlights that even the most highly functioning clinics require improvement in their discussions about weight. If even a highly-rated clinic has room for improvement, examining and assessing communication about weight in less highly rated clinics becomes even more necessary.

Chapter 5: Well-Child Visits with Approaching/Underweight Children

The sampled well-child visits include three underweight patients (defined as less than the 5th BMI percentile)[35] and two patients here defined as "approaching underweight" (defined as 5th—8th BMI percentile). For the sake of brevity, approaching underweight and underweight patients will be referred to as "approaching/underweight" for the remainder of the chapter. Child BMI was calculated based on the parent report of the child's height, weight, age, and gender in the post-visit questionnaire. Approaching underweight patients were included in the analysis because care providers appeared to treat these patients similarly to the underweight patients. Figure 6 outlines the key findings for underweight and approaching underweight patients.

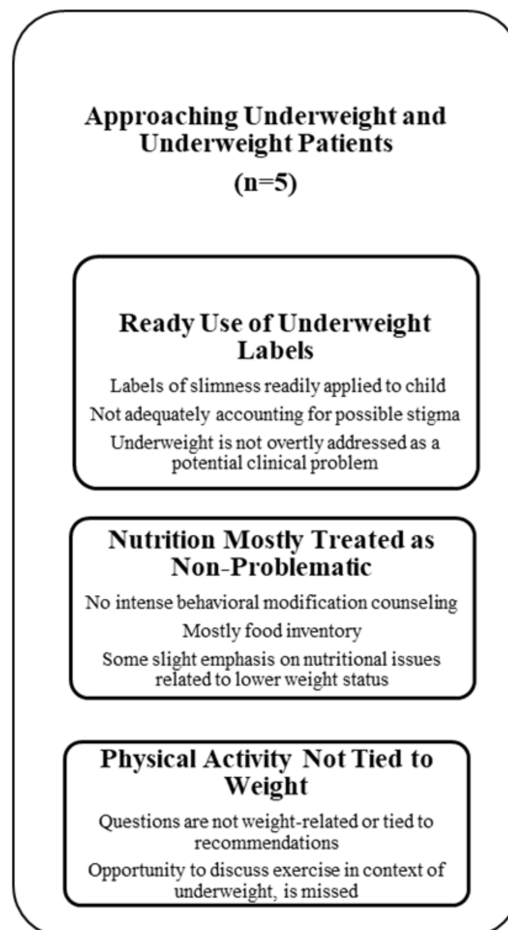

Figure 6: Key findings for underweight/approaching underweight patients (n=5).

Discussions about diet, physical activity, and weight with approaching/underweight patients exhibit similarities to both the non-problematic, normal weight discussion and properties of the overweight, problematic discussion.

First, care providers readily apply weight-based labels of slimness to approaching/underweight patients. The blithe use of these labels does not account for the possible stigma associated with these terms. Parents do not overtly resist these labels. However, parents do argue against the stigma these labels imply, that low weight status indicates a misbehavior on the part of the parent or child. Despite the use of weight-based labels, underweight status is not particularly addressed by the care providers in any of the well-child visits, nor framed as a potential clinical problem in need of focused care-provider attention.

Second, discussions about nutrition with approaching/underweight patients reflect a mostly non-problematic stance. There is no intense behavioral modification counseling, and the discussion mostly progresses as a food inventory. Yet, in nearly half of the well-child visits with approaching/underweight patients there is a subtle emphasis on nutritional issues relevant to an underweight status like iron consumption, red meat consumption, and anemia prevention.[67–69] This subtle emphasis exemplifies the treatment of approaching/underweight patients in the sampled well-child visits—they are *mostly* treated like normal weight patients and their weight status is *mostly* treated as normal—but there are also subtle differences.

Third, in well-child visits with approaching/underweight patients physical activity is not tied to weight. Questions regarding physical activity are not weight-related and are not tailored to weight-based recommendations. Thus, the opportunity to discuss physical activity in the context of underweight status is missed.

The above findings, taken together, argue that approaching/underweight patients are treated as *liminally* healthy—occupying the space between healthy and problematic. The liminal treatment of approaching/underweight patients is significant because care provider treatment of these patients appears to be somewhat inconsistent and haphazard. As outlined above, the language taken with approaching/underweight patients is not as careful as the language used with overweight/obese patients, and labels of thinness are readily applied to patients. Additionally, the emphasis on nutritional issues relevant to underweight status is present in some, but not all of the visits, and may be too subtle for parents to truly understand potential nutritional issues relevant to underweight status—leaving underweight patients vulnerable to nutritional deficits or underlying conditions.

Ready Use of Underweight Labels without Accounting for Possible Stigma

Care providers in half of the well-child visits with approaching/underweight patients readily label the child using labels of slimness. Similar to the treatment of normal weight patients (see Chapter 3), the potential stigma surrounding these labels does not appear to be adequately accounted for. Additionally, because these children are underweight or approaching underweight, they may be receiving similar messages from other sources. Thus, the care provider's use of these labels may be particularly harmful.

"So, you're a lean guy"

The care provider applies a weight-based label in the subsequent well-child visit with an 11-year-old underweight boy (4th BMI percentile) and his mother:

1) Pediatrics 13.5

1 Care Provider 1: Good. You want to look at your growth chart?
2 Child: Let's see.
3 Care Provider 1: Let me pull it up. So, here we go. So, we like to see him following a curve, which
4 he's doing awesome. You can see it starting to bend up. This is your weight right
5 here. You're 67 pounds today. And he's kind of been in like the 15th percentile

6 for weight.
7 Mom: And is that still pretty much where he's at?
8 Care Provider 1: Yeah. It's- it's he's established himself along that curve, and he's been following
9 it wonderfully. And, uh, it seems like he has a good appetite and a varied diet, so
10 that's perfect. And then you're tall, so he's up towards the 50th percentile for his
11 → height. **So, you're a lean guy.** Um and that is – yeah, he's exactly 52 percent
12 today, so.
13 Mom: → Okay. And how tall is he right now?
14 Care Provider 1: He is 56.7, so almost almost 57 inches.

Before the excerpt above, the care provider asked a series of questions ranging from diet, to bowel movements, to sleep. The care provider then switches to the growth chart (line 1) and continues the discussion of the growth chart with, "So, we like to see him following a curve, which he's doing awesome." (lines 3-4). In this way, the care provider labels the growth chart information as positive news and evidence of a non-problematic status since the child is "following a curve" (line 3). The care provider continues to provide evidence for a non-problematic weight-status by describing the growth curve as, "starting to bend up" (line 4) and providing the details of the child's weight and weight percentile (lines 4-6).

The mom requests clarification with, "And is that still pretty much where he's at?" (line 7). The mother's question indicates that she does not yet understand what this information means in terms of her son's growth and overall weight-status. To answer the mother's question about the son's growth, the care provider offers a series of reassurances to assure the mother of the son's healthy status (lines 8-12). First, the care provider repeats that the son is following his growth curve with, "Yeah. It's it's he's established himself along that curve, and he's been following it wonderfully." (lines 8-9). With this statement the care provider again provides reassurance of the son's growth being along his growth curve, and overtly marks the growth as progressing "wonderfully" (line 9). Second, in lines 9-10, the care provider argues for reassurance of the son's healthy status by emphasizing the son's healthy eating behaviors with

"And, uh, it seems like he has a good appetite and a varied diet, so that's perfect." The care provider's *and-prefaced response* [64] (line 9) indicates that this piece of information about the son's diet functions as a further point of evidence in an ongoing case to reassure the parent and child of the child's overall healthy status. Third, in lines 10-11, the care provider reassures by marking the son's height as an explanation of the son's growth curve, "And then you're tall, so he's up towards the 50th percentile for his height." Again the care provider uses an *and-prefaced response* [64] (line 10) to mark this information of the son's height as a further indication of the son's overall healthy status. Finally, the care provider summarizes the son's growth and the results of the growth chart with a weight-based identity label: "So, you're a lean guy" (line 11).

As was done with normal weight patients (see Chapter 3), the care provider in the excerpt above works to reassure the parent and child of the child's healthy status, *despite the fact that the child is underweight, with a BMI in the 4th percentile*. To accomplish reassurance, the care provider embarks on a series of statements including reassurance of the son's growth curve (lines 8-9), eating habits (lines 9-10), and height (lines 10-11). Finally, the care provider applies a weight-based label "So, you're a lean guy" (line 11) to diminish the son's underweight status as an aspect of his identity rather than a clinically relevant problem. This treatment is nearly identical to the treatment of normal weight patients and use of "smallness" and "thinness" labels explored in Chapter 3. The danger with this approach to reassurance is that it relies on a weight-based label, which is itself potentially stigmatizing,[44] and assumes that labels of smallness and thinness are unequivocally positive and preferred. The mom's response in line 13, "And how tall is he right now?" indicates that she is returning to the care provider's previous assessment about her son's tallness (line 10), perhaps as a possible explanation and justification of his slenderness, and a subtle challenge to the stigma surrounding this label.

“he’s so like tall and slim”

The care provider in the following well-child visit, with an underweight 10-year-old boy, at first does not apply a weight-based label during the discussion of the growth chart:

2) Pediatrics 14.5, and 14.14

1	Care Provider 1:		Oh, yeah. That won’t do it. Let’s take a look. So, I mean, I think overall, you’re
2			you’re gaining weight okay. You’re 69 pounds, about the 43rd percentile. Um, so,
3			that’s okay. And then you’re like crazy tall and growing, as you normally are. Oh
4			my gosh. Almost-good grief! Almost five feet tall. You’re 59 inches, 94th
5			percentile. So, when we look at your height for your weight. You’re always kind
6			of at the, ya know, low end.
7	Mom:	→	**Skinny!**
8	Care Provider 1:		[inaudible] for a guy.
9	Child 1:		69 pounds.
10	Mom:		He eats! Yeah, I think it’s just the way that he’s… kind of always been.
11	Care Provider 1:		Were you or his dad like that as young children?
12	Mom:		I guess, I-- I was, I’m lanky.
13	Care Provider 1:		Yeah.
14	Mom:		Lanky… or still am.
15	Care Provider 1:		All right. Now, um what grade are you in?
	[14 minutes and 94 seconds later in the same visit the Care provider and Mom are discussing the son’s posture]		
16	Care Provider 1:		I think your mom’s right. I think you do need to stand stand up straight. And he
17		→	may be, like you just notice it that much more because **he’s so like tall and slim.**
18	Mom:		Yeah [In overlap]
19	Care Provider 1:		That any little bit of
20	Mom:		Yeah [in overlap]
21	Care Provider 1:		deviation from super straight, you’re gonna see more of with him [inaudible], but
22			I think it looks okay.
23	Mom:		Okay.

In the excerpt above, the care provider begins by offering the results of the child’s growth (lines 1-3). In fact, the care provider summarizes the child’s weight results as “okay” twice (lines 2 & 3), emphasizing the “okay” evaluation. Yet, the care provider’s non-verbal delivery of the word “okay” (lines 2 & 3) indicates that this evaluation is not extremely positive, but adequate at best. In contrast, the care provider unequivocally affirms the child’s height (lines 3-5). The cautious evaluation of the child’s weight gain as “okay” (lines 2 & 3) compared to the enthusiastic evaluation of the son’s height as “crazy tall” (line 3), delicately marks the child’s

weight as potentially problematic. Subsequently, in lines 5-6, the care provider combines the results of the child's height and weight to inform the parent and child about the child's overall growth and weight status with, "So, when we look at your height for your weight. You're always kind of at the, ya know, low end.". With this statement the care provider, somewhat abstractly, informs the child of his underweight status, by commenting that he is "kind of at the, ya know, low end." (lines 5-6).

Following the care provider's statement, the crosstalk between the various speakers is somewhat inaudible, but the mother clearly states, in response, "Skinny!" (line 7). In this way, the mother, herself, applies a weight-based label to the child, based on the results from the growth chart. In line 10, the mother attempts to account for the child's low weight status with, "He eats! Yeah, I think it's just the way that he's… kind of always been.". The mother's statements here indicate that she views the child's low weight status as requiring an accounting, and perhaps a justification or explanation from herself as the parent. The mother's response highlights that, similar to overweight status, underweight status also carries with it a stigma[44] and possibility for blame for both the parent and child.

The care provider appears to accept the mother's non-problematic account of her child's eating behavior, and instead explores a genetic cause for the underweight status with, "Were you or his dad like that as young children?" (line 11). The care provider's acceptance of a possible genetic explanation for the child's underweight status marks a difference between how underweight and overweight are treated clinically. While overweight status was immediately followed by behavioral counseling and assumptions about eating and exercise behaviors[62] (see Chapter 4), underweight status seems to be allowed other possible explanations (i.e., genetic factors). The mother appears to accept this line of inquiry and responds with, "I guess, I-- I was,

I'm lanky." (line 12). The care provider agrees with the mother (line 13), and, in line 15, the care provider switches topics by initiating a discussion about the son's school. Notably, at no point in the interchange (at least audibly) does the care provider apply a weight-based label to the child.

Conversely, later in the visit, the care provider is assessing the child's posture. The care provider comments, "I think your mom's right. I think you do need to stand stand up straight. And he may be, like you just notice it that much more because he's so like tall and slim." (lines 16-17). Here the care provider applies a weight-based label to the child to explain and reassure the parent and child regarding the child's posture. The mother provides acknowledgment of the care provider's assessment with the *response token*,[60] "Yeah" (line 18). The care provider continues to explain that the child's posture seems more problematic than it actually is because of the child's body type (lines 19 & 21) and ultimately, "looks okay" (line 22). In this way, the care provider clarifies that the perception of slouched posture may be explained by the child's tallness and slimness. Nonetheless, this labeling, although potentially reassuring regarding the child's posture, does not take into account that being labeled "so" "slim" may be stigmatizing[44] for a 10-year old boy, especially given that this boy is underweight and has likely heard similar comments before from peers or parents. Akin to the application of the 'labels of smallness and thinness' with normal weight children, the labels of slimness with underweight children indicate that care providers may not view these labels as stigmatizing, and in fact, use these weight-based labels in an attempt to reassure.

Both excerpts 1 and 2 (above) illustrate how the care providers' ready use of underweight labels does not adequately account for the possible stigma surrounding these labels. As was the case for normal weight patients, care providers appear to use these labels to reassure parents and children that the child's body size (and other aspects of body carriage, like posture) is the child's

identity, rather than a clinically relevant concern. Although perhaps initially reassuring, the blithe application of potentially stigmatizing labels of thinness (i.e., "so you're a lean guy")[47–49] could risk harming the child's self-image and promote a dis-preferred identity.[44]

Notably, neither the parents nor children, in excerpts 1 and 2, appear to actively resist the labels of thinness. One reason could be because of the care provider's medical authority. Specifically, the care provider may be viewed as having the authority to provide statements on the patient's health and person—even if these labels are dis-preferred. Nonetheless, although the parents do not actively resist the label, they appear to *justify* the child's smaller size. In excerpt 1 (line 13), the mother responds to the care provider's label of thinness by asking about the care provider's prior assessment of her child's tallness. The mother's question implies that the child's leanness could be a result of his tallness—rather than a problematic condition. Similarly, in excerpt 2, after the mother labels the child herself (line 7), she justifies that the child is eating enough (line 10) and that he has always been a low weight (line 10). When the care provider labels the child as thin later in the visit (line 17), the mother does not resist the label—perhaps because she has already labeled the child as thin (line 7) and has also previously explained why the child's thinness is not a result of negligent eating behavior (line 10). Thus while not actively resisting the label—the parents in excerpts 1 and 2 are resisting possible stigma (or the spoiled identity)[44] implied by the label—that the lower weight status indicates negligence of care on the part of the parent or child.

Nutrition Mostly Treated as Non-Problematic

According to the National Center for Health Statistics[70] the main clinical concern for underweight children is that the underweight status indicates malnutrition or is caused by a potential underlying condition. Nutritional assessment should thus be given an intentional role in

the treatment of underweight children—not for the sake of ensuring weight gain, but to ensure that the child is not malnourished. Previous research also indicates that underweight status can be a risk factor for anemia[68,69] and iron deficiency.[67] In the sampled well-child visits care providers are inconsistent, and somewhat haphazard, in their discussions of nutrition with approaching/underweight patients. Care providers mostly treat the child's lower weight status as non-problematic. None of the care providers offer structured counseling for changes in diet or weight management. This finding sharply contrasts with the finding that care providers overtly counsel overweight and obese patients on dietary changes in both content and amount (see Chapter 4). In this way, underweight patients are treated similarly to normal weight patients, and their eating habits are tacitly framed as non-problematic and weight-gain is not particularly emphasized. Nonetheless, several of the well-child visits included a subtle emphasis and careful assessment of iron-consumption/anemia prevention as part of the food inventory portion of the well-child visit.

Treated as Non-Problematic

In the majority of well-child visits with approaching/underweight patients the discussion about diet progresses without particular emphasis on lower weight. The patient's eating behavior, and by implication, overall weight status is treated as non-problematic. Given that underweight status can indicate malnutrition, the care provider's non-problematic approach to nutrition assessment may not be ideal, and could leave the child at risk.[70]

"Green vegetables or meat".

The well-child visit next presented is with a 9-year-old girl approaching underweight status with a BMI in the 7th percentile. Previous to this excerpt the care provider, mother, and girl were discussing the girl's nervousness and anxiety, specifically, her anxiety about swimming

class at school. It is anxiety rather than weight management that is the main focus of the well-child visit:

3) Pediatrics 3.8

1	Care Provider:	Good, alright. Um getting some uuh calcium in your diet? Some milk, cheese,
2		yogurt–type things? Good.
3	Mom:	Ice cream.
4	Care Provider:	Mmm, wonderful. Umm and umm how about umm some iron in your diet?
5		Green vegetables or meat or – Mm-hmm, good.
6	Mom:	We eat that every day.
7	Care Provider:	Mm-kay. Sleeping okay?

The care provider quickly introduces the topic of nutrition in line 1 asking specifically about calcium, and assessing if the child is consuming, "Some milk, cheese, yogurt-type things?" (lines 1-2). The mom, jokingly, replies "Ice cream" (line 3). The care provider then quickly evaluates if the daughter is consuming iron, vegetables, and meat (lines 4-5). In line 7, the care provider then shifts the discussion to the daughter's sleeping. Neither the mother nor the care provider treat the daughter's eating behavior as requiring specific, focused attention. Rather, lines 1-7 depict a routine and remarkably brief food inventory. Similar to well-child visits with normal weight patients (see Chapter 3), the care provider does not offer any targeted counseling or behavioral recommendations. In this way, the daughter's eating behavior is tacitly marked as non-problematic—an afterthought rather than an issue worthy of particular attention. The lack of specific focused attention in the nutritional discussion misses an opportunity to assess possible nutritional issues relevant to underweight status, like iron-deficiency, anemia, or malnourishment, [67–70] potentially leaving the patient more at risk for these conditions.

"eating some healthy foods like fruits and vegetables".

The following well-child visit, with a 10-year-old underweight boy, is conducted quite quickly. The care provider rapidly moves from question to question:

4) Pediatrics 14.5

1	Care Provider 1:	Now, [child's name], are you eating breakfast, lunch, and dinner? Yeah?
2	Child 1:	I eat a lot, but I never get bigger.
3	Care Provider 1:	Okay. You eat a lot. You never get bigger. Are you eating some healthy foods
4		like fruits and vegetables?
5	Child 1:	Mm-hmm. I like blueberries and carrots.
6	Care Provider 1:	Are you getting some milk to help your now what look like crazy growing
7		bones? Yeah, you're eating you're drinking a lot of milk? Okay, good. And
8		getting some good um foods to help keep your muscles strong, so foods with
9		iron, like meats or beans or tofu?
10	Child 1:	Mm-hmm.
11	Care Provider 1:	Or dark green leafy veggies, which you have to eat a lot of? Okay. So, you're
12		doing okay with that. Do you see a dentist who takes care of your teeth?

The care provider begins by asking if the child eats "breakfast, lunch, and dinner?" (line 1). The child responds by referencing his underweight status, and initiating a subtle concern about his weight with, "I eat a lot, but I never get bigger" (line 2). The child here acknowledges that he is unable to "get bigger," despite eating "a lot" (line 2). The child's statement functions as both a bid for further information from the care provider and also an accounting for and justification of his eating behavior as non-problematic, despite his underweight status. The care provider echoes the child's words with "You eat a lot. You never get bigger." (line 3). However, the care provider does not address or respond directly to the child's expressed concern. The care provider does not explain, or provide further information or reassurance, to the child for why he eats and does not get bigger. Instead, the care provider immediately continues with the rapid food inventory, by asking if the child eats fruits and vegetables (lines 3-4).

This instance provides a strong example of the care provider dis-attending the child's concern about not getting any bigger in favor of continuing the medical agenda—in this case, the nutritional assessment. Previous conversation analysis work has similarly found that when a patient provides a psychosocial concern, the care provider does not address the concern, even when the concern is brought up repetitively, and instead continues to adhere to the medical

agenda of the visit.[71] Disattended patient concerns have significance because, "When patients' basic needs and concerns are unmet—even as a result of their inability to raise them directly—patients seek return visitations, including ERs, because their stated problems were not heard and attended to in prior encounters".[71(pp362-363)]

In line 6, the care provider acknowledges that the child is quite tall, and requires specific nutrients to grow well, by asking, "Are you getting some milk to help your now what look like crazy growing bones? (lines 6-7). The care provider's framing of the child as has having "crazy growing bones" (lines 6- 7), refers to the child's height, which is later discussed in the visit, but does not reference the child's weight, previously brought up by the child in line 2. The care provider continues framing the child's height and rapid growth as requiring specific nutrients by stating, "And getting some good um foods to help keep your muscles strong, so foods with iron, like meats or beans or tofu?" (lines 8-9). In lines 6-8, the care provider is careful to ensure that the child is getting the specific nutrients and food groups he needs to support his growth. But there has been, up to this point, no counseling or recommended changes to the child's diet. In line 11, the care provider delivers the only counseling component present in the diet discussion with, "Or dark green leafy veggies, which you have to eat a lot of?" (line 11). Here the care provider subtly recommends that the child eat "a lot of" dark green leafy veggies. This brief mention, although highlighting the need for an iron source, does not particularly address the child's concern about his underweight status, brought up earlier in line 2. The child's concern remains unaddressed, and his eating behavior fully treated as non-problematic and not in need of a specific counseling component.

Excerpts 3 and 4 (above) provide examples of how approaching/underweight status is often framed as non-problematic in well-child visits. The dietary portion of the well-child visits

takes the form of a food inventory with specific questions and answers rapidly asked and answered, similar to the treatment of normal weight patients (see Chapter 3). Even when a child initiates a concern about low weight status (as was the case in excerpt 4), the care provider maintains the agenda of assessing the intake of specific types of food groups and nutrients, without particularly noting or counseling the parent or child in reference to the child's weight status. The child's concern about not getting bigger is dis-attended, in favor of maintaining this medical agenda.[71] This treatment marks a deviation in the treatment of underweight as compared to overweight/obese, in which the care provider overtly, and sometimes overly overtly addresses and assesses the role of eating behavior in the child's weight status. This treatment also highlights that underweight is framed as not requiring the same amount of clinical attention as overweight or obese status. Potential health concerns related to underweight status, like malnutrition, iron-deficiency, and anemia,[67–70] remain mostly unaddressed even in the dietary discussion. In this way, the child is potentially left at risk for these conditions—and the parent uninformed.

Nutrition Portion Includes Subtle Emphasis on Iron and Cautions Against Anemia

In a little less than half of the well-child visits there is subtle counseling about iron intake and/or anemia prevention. This emphasis on these potential conditions appears to be in line with previous research indicating that underweight status can be a risk factor for anemia [68,69] and iron deficiency,[67] and could also indicate malnutrition or another underlying condition.[70] The counseling is subtle because (as illustrated in the excerpts below) the care providers specifically underscore questions related iron intake and/or anemia, but the link between these conditions and lower weight status is not overtly mentioned. Furthermore, the care providers do not openly recommend or outline specific dietary changes. Care providers' subtle counseling of

approaching/underweight patients reflects the concerns of previous research,[67–70] and embodies a stance toward lower weight patients in which they are treated as *mostly* healthy but not fully and completely healthy.

"Does she eat any red meat".

The next well-child visit is with a five-year-old girl who is approaching underweight status at the 8th BMI percentile. The following lengthy excerpt is included to depict how the nutrition portions integrate a subtle emphasis on iron, with a light counseling segment about anemia prevention and iron:

5) Pediatrics 6.7

1	Care Provider 1:	Okay. Um how much milk is she drinking each day?
2	Dad:	Uh she's probably drinking like a glass of milk a day. Like one of the shorter
3		glasses.
4	Care Provider 1:	Okay. Like around eight ounces?
5	Dad:	Probably, yeah. Probably one of those a day.
6	Care Provider 1:	Okay.
7	Dad:	And then the rest of the dairy's gonna be yogurt a yogurt and a cheese stick a
8		day.
9	Care Provider 1:	Okay. And that's one of the things we ask uh because we obviously want kids to
10		get their calcium and everything.
11	Dad:	Okay.
12	Care Provider 1:	But sort of the upper limit of what we say we don't want to surpass is 24 ounces
13	Dad:	Okay.
14	Care Provider 1:	or like three glasses of milk.
15	Dad:	Okay.
16	Care Provider 1:→	That's just because some of the proteins of milk **can cause anemia** if you drink
17		too much of it.
18	Dad:	Okay.
19	Care Provider 1:	Um but she's not anywhere near that, so.
20	Dad:	Super. All right.
21	Care Provider 1:→	Okay. Um and is she getting **a good mix of like veggies, meats**?
22	Dad:	Yup.
23	Care Provider 1:	Okay.
24	Dad: →	She's our **she's our eater.**
25	Care Provider 1:	Okay.
26	Dad:	She loves everything.
27	Care Provider 1:→	All right. Is she a **picky eater**?
28	Dad:	She is not, no.
29	Care Provider 1:	Okay.
30	Dad:	She she she loves all sorts of stuff. Yeah. My wife and I have been doing the
31		Hello Fresh meals.

32	Care Provider 1:	Oh. Okay.
33	Dad:	So we get meal deliveries, and we try new meals.
34	Care Provider 1:	Okay.
35	Dad:	She wants to eat all of them.
36	Care Provider 1:	Okay.
37	Dad:	It's great, yeah.
38	Care Provider 1:	All right. So, no like dietary restrictions or anything like that.
39	Dad:	No.
40	Care Provider 1:→	Okay, good. Okay. **And how's she been getting her iron**? Like through meat,
41		cereal?
42	Dad:	Uh. probably through, yeah, both.
43	Care Provider 1:	Okay.
44	Dad:	She has, depending on the mornings, some mornings are either oatmeal or uh
45		Trader Joe's waffles or cereals.
46	Care Provider 1:	Okay.
47	Dad:	Or uh. So, a little bit through that, and then I guess the rest of it's through meat.
48	Care Provider: 1:	Okay.
49	Dad: →	She's our she's **our eater. So she loves**
50	Care Provider 1:	Oh, that's great.
51	Dad:	turkey and chicken and uh.
52	Care Provider 1:	Yeah.
53	Dad:	And we usually have a rotisserie chicken in the house
54	Care Provider 1:	Okay.
55	**Dad:**	and she eats that all the time.
56	Care Provider 1:→	Does she eat any red meat?
57	Dad:	She does, yeah.
58	Care Provider 1:	Okay.
59	Dad:	She eats bison.

The lengthy excerpt above is mostly a food inventory, focusing on consumption of particular nutrients as well as fruits and vegetables. This extended excerpt provides an example of the how both iron consumption and anemia prevention are emphasized throughout the course of the nutritional discussion, but are not treated as requiring specific modification. This excerpt also illustrates how the dad consistently insists that his daughter is a good eater—and thus resists a possibly implied stigma that a lower weight child is one who is not eating enough.

The dad has mentions that the daughter drinks milk and eats yogurt and cheese (lines 2, 7-8). The care provider responds to this information by cautioning the dad about anemia risk (lines 9-10; lines 16-17). However, the care provider assures the dad that the daughter is not consuming enough dairy for anemia risk to be a true concern (line 19). The care provider's

particular attention to dairy and anemia risk reflects a potential concern related to underweight status,[68,69] although not overtly mentioning underweight or directly counseling on specific dietary changes.

Similarly, in line 21, the care provider particularly asks about veggies and meats. Then again in line 40, the care provider focuses specifically on iron and meat consumption, and queries about red meat (line 56) and frequency of eating red meat (later in the visit), indicating the need to have specific and targeted information about these eating behaviors. The care provider's focus on anemia (lines 16-17), picky eating (line 27), and iron and red meat consumption (lines 40, and 56) reflects an emphasis on issues relevant to a lower weight status.[67–69] Although not overtly addressing the child's approaching underweight status, the care provider subtly indicates a concern about diet and the daughter's eating.

Throughout the course of the well-child visit the dad consistently re-iterates that his daughter is a good eater—despite her lower weight status. When the care provider asks about veggies and meats (line 21), the dad responds, "She's our she's our eater" (line 24). The dad reiterates this point again with, "She loves everything." (line 26). Despite the dad's overt and repetitive assertion that his daughter is a good eater, the care provider responds with, "All right. Is she a picky eater?" (lines 27). The care provider's question about picky eating, indicates either that the dad's comments about the daughter's eating (lines 24 and 26) were not heard or were not sufficient to account for his daughter's more slender weight, and thus require a formal question and reiteration. To which the dad, again, asserts that the daughter is not a picky eater (line 28). In fact, the dad continues to describe what a good eater his daughter is in that she, "loves all sorts of stuff" (line 30), and when trying meals from the meal delivery service "she wants to eat all of them" (line 35). Finally, in line 49, the dad again comments that the daughter is "our eater" (line

49). The dad's repetitive assertion that his daughter is a good eater (lines 24, 26, 30, 35, and 49) indicates that he may feel a need to account for, explain, and perhaps justify his child's more slender weight—and possibly even fight against the stigma that a lower-weight child is one who is not eating enough.

"do beef at home at all".

In the subsequent well-child visit with an 11-year-old underweight boy and his mother, the visit mostly progresses like a routine food inventory, with specific questions about foods. However, there is again subtle emphasis on ensuring sufficient iron consumption:

6) Pediatrics 13.4

1	Care Provider 1:→	Do you have any **meats, like red meat or beef or chicken?**
2	Child:	We have chicken.
3	Care Provider 1:	What about fish?
4	Child:	Not really.
5	Care Provider 1:→	Not too much fish? Um do you do you do **beef at home at all?**
6	Mom:	Sometimes.
7	Care Provider 1:	And how about any fruits?
8	Child:	Mm.
9	Care Provider 1:	So, it sounds like a pretty varied diet. What are your favorite snacks?
10	Child:	Well, at camp, well, just because I have sometimes trail mix, like so like nuts,
11		raisins.
12	Care Provider 1:	Nice. And then – go ahead, keep going.
13	Child:	And then today, I had celery and carrots. Yeah.
14	Care Provider 1:	Oh, very healthy. And do we have does he drink milk? How often, would you
15		say?
16	Mom:	Do you generally drink it at lunch?
17	Child:	Yeah.
18	Mom:	So, I would say . . .
19	Care Provider 1:	Like once a day?
20	Mom:	Two to three times a day.
21	Care Provider 1:	Okay.
22	Mom:	Two percent. That what you drink at school, actually.
23	Care Provider 1:	Good.
24	Mom:	Two perecent.
25	Care Provider 1:→	And then, so for **iron sources, we have a little bit of of beef** sometimes. Does he
26		do beans or lentils at all?
27	Mom:	Uh sometimes, we're not it's not a huge part of our diet.
28	Care Provider 1:	Okay.
29	Mom: →	**Maybe we should add it in.**
30	Care Provider 1:→	**Yeah. Those are great sources of of iron.** Dental care established?

In lines 1-24, the visit mostly progresses like a routine food inventory with specific questions and answers about food groups. The care provider asks about overall meat consumption (line 1), beef consumption (line 5), fruits (line 7), snacks (line 9), and milk consumption (line 14). However, in line 25, the care provider, again, returns to the subject of meat consumption and iron, an important nutritional aspect for underweight status,[67] asking, "And then, so for iron sources, we have a little bit of beef sometimes. Does he do beans or lentils at all?" (lines 25-26). The mom responds, "Uh sometimes, we're not it's not a huge part of our diet." (line 27). The mom follows up on her comment with, "Maybe we should add it in." (line 29). The care provider agrees and states, "Yeah. Those are great sources of of iron." (line 30).

The care provider's subtle emphasis on iron consumption illustrates that the care provider may view iron-consumption as a possible concern, at least enough of a concern to initiate questions about iron sources several times throughout the well-child visit with a focus on meat (line 1), beef (line 5), and iron sources (lines 25-29). In this way the care provider addresses and potentially mitigates one of the risks of underweight status, iron-deficiency,[67] without overtly discussing or highlighting the child's low weight.

When discussing diet with approaching/underweight patients and parents, care providers treat patients as *liminally* healthy. Patients are *mostly* treated as healthy and non-problematic. Yet, patients are also, sometimes, subtly reminded of their approaching/underweight status, with questions highlighting iron-consumption and anemia. The excerpts above illustrate that the dietary assessment of conditions relevant to underweight status are only haphazardly addressed with a subtle emphasis on iron consumption and anemia in some, but not all, of the visits with approaching/underweight patients. This haphazard and subtle treatment leaves patients

potentially exposed to nutritional deficits and parents uninformed and uneducated on how to ensure that their children are getting the nutrition that they need.

Physical Activity Framed as Non-Problematic

None of the discussions of physical activity were tailored to underweight status. In this way, physical activity with approaching/underweight patients was addressed similarly to normal weight patients, as non-problematic and not requiring behavioral change. The minimal treatment of physical activity misses an opportunity to discuss how physical activity may be protective for approaching/underweight patients—paying particular attention to relevant issues like bone mineral density, aerobic capacity, and muscle strength, as has been done in previous research with underweight patients.[72] Additionally, care providers do not take into account any barriers to physical activity specific for approaching/underweight patients—like potential self-image considerations or physical limitations.

"Okay, so you're an active guy"

The well-child visit below, with a 10-year-old underweight boy, provides a classic example of how exercise is minimally evaluated and tacitly treated as non-problematic, similar to normal weight patients (see Chapter 3):

7) Pediatrics 14.6

1	Care Provider 1:→	Yeah? Doing any activities after school?
2	Child 1:	Uh yeah. Some days, we go to after care, and we do outdoor games and Legos
3		and stuff.
4	Care Provider 1:	Okay.
5	Child 1:	I play wall ball at recess almost every day.
6	Care Provider 1:→	Okay, so you're an active guy.
7	Mom:	And then what else do you do? You do gymnastics.
8	Child 1:	Gymnastics and basketball.
9	Care Provider 1:	Okay. You're doing everything, basically.

In line 1 the care provider inquires about afterschool activities. The boy responds that “we do outdoor games and Legos and stuff” (lines 2-3). The boy continues to explain that he also plays ball at recess (line 5). The care provider appears to view this discussion of exercise as sufficient and begins to close the topic by summing up the boy’s activity level with a *so-prefaced* utterance: “so, you’re an active guy” (line 6). The care provider’s *so-prefacing* frames: “so, you’re an active guy” as a “natural continuation of patient’s proceeding reportings…en route to shift of topic”.[73(p27)] However, the mom continues the discussion about exercise by prompting the boy to provide more information (line 7). The boy provides the information (line 8), and the care provider responds by, once again, summarizing the information with, “Okay. You’re doing everything, basically” (line 9).

The care provider’s comments and questions about exercise are fairly minimal. The only question the care provider asks is the general question about afterschool activities (line 1), and the care provider is quick to attempt to close and shift topics (lines 6 and 9). The care provider’s minimal attention to physical activity indicates that, for approaching/underweight patients, physical activity is not viewed as problematic or requiring specific attention. In this way, care provider approach to physical activity with approaching/underweight patients is similar to care provider approach to physical activity with normal weight patients (see: Chapter 3).

The minimal treatment of physical activity emphasizes that underweight, and even severely underweight children (see Excerpt 7 with child in the 2nd BMI percentile), are not viewed as requiring specific behavioral changes in regard to physical activity. Although underweight patients may deviate from the normal, their condition is not framed as requiring changes in physical activity or particular clinical attention. This minimal treatment of physical activity does not take into account that it might be important for care providers to assess exercise

in a way that is specific for approaching/underweight patients, paying attention to health considerations like bone mineral density, aerobic capacity, and muscle strength, as has been done in previous research with underweight patients. [72] The opportunity to discuss exercise in the context of approaching/underweight status is missed. For example, would a severely underweight child have specific barriers to certain types of exercise or physical activities? Is there a context in which exercise as a mechanism for healthy weight-gain could be implemented as well as any resources for promoting exercise with the purpose of weight gain? Such questions are not asked in the sampled well-child visits, and such topics are not addressed.

Chapter Summary

The above findings, taken together, argue that approaching/underweight patients are treated as *liminally* healthy—occupying the space between healthy and problematic. Care providers are less careful to avoid stigmatizing terms and readily use underweight labels. Similarly, care providers mostly discuss and frame discussions about diet as non-problematic. However, care providers can also subtly hint at, and focus on issues particular to underweight status like iron-deficiency and anemia,[67–69] without overtly counseling on these issues. Physical activity is not framed as particularly important and is not tailored to underweight status.

Such liminality has potentially significant public health consequences. If care providers are unclear about the status of underweight as a health problem or not a health problem, there may be less care taken in how underweight status is addressed. In fact, the care of approaching/underweight patients appears inconsistent and haphazard in the sampled well-child visits. Specifically, care providers label underweight children using stigmatizing terms, likely because these terms are not viewed as stigmatizing by the care providers. However, for children and parents these terms could be stigmatizing and promote a dis-preferred identity.[44,47–49] Despite

the potential stigma of such labels, parents and children in the included well-child visits do not actively resist the care provider's labels. Instead, they resist the possible stigma (or spoiled identity)[44] implied by the label—that the lower weight status indicates negligence of care on the part of the parent or child. Parents resist this implied stigma by pointing to the child's height to explain the thinness (excerpt 1), defending the child's eating behavior (excerpt 2), and highlighting genetic causes of the thinness (excerpt 2). Additionally, care providers take less care in discussing nutritional issues relevant to underweight status than was done with overweight/obese patients. The emphasis on nutritional issues relevant to underweight status is present in some, but not all of the visits, and may be too subtle for parents to truly understand potential nutritional issues relevant to underweight status—potentially leaving underweight patients vulnerable to nutritional deficits or underlying conditions. Although perhaps less pressing than addressing overweight and obesity, underweight status also requires intentional care in both language used in addressing patients, and careful assessment when discussing nutritional needs.

Link to Quantitative Findings

The above findings are more fully contextualized when integrated with the quantitative findings from Chapter 2. As mentioned in the previous chapter, the high parent-reported satisfaction with both the overall medical visit and care provider communication about weight, diet, and physical activity, indicates that even though the qualitative analysis elucidates a need for improvement, parents were overall quite satisfied. In this way, the quantitative findings help to contextualize the qualitative findings because they remind the reader that even a clinic that is well-rated by parents still requires improvements in care provider communication. These findings also emphasize the benefit of a conversation analysis approach in that it can identify

areas of communication improvement that might not be readily identifiable through quantitative measures alone.

Chapter 6: Review of Major Findings, Implications, and Directions for Future Research

The present study is the first to focus directly on care provider, parent, and child well-child visit discussions about weight, diet, and physical activity as well as linking these to parent-reported satisfaction with physician communication. This mixed method study—utilized conversation analysis of 39 well-child visits (approximately 17 hours of recording) in unison with a quantitative post-visit questionnaire to assess care provider, parent, and child communication about weight, diet, and physical activity.

Major Findings

Quantitative Findings

Research question 3.

The quantitative analysis was guided by the research question: *How satisfied are parents with care provider communication about weight, diet, and physical activity and what factors (if any) are related to satisfaction?* The use of a quantitative post-visit questionnaire enabled an assessment of parent overall satisfaction with the well-child visit as well as satisfaction with weight, diet, and physical activity, in particular. Specifically, it allowed for an analysis of what parent and child demographic factors or care provider factors might be related to this satisfaction.

Results.

Overall, 89.7% of parents reported that the care provider discussed diet, physical activity, or weight with them. Additionally, parents reported being highly satisfied with their child's medical visit, with the median score being the highest possible response value (M*d*=5, *IQR*: 5,5).

Quantitative analysis explored possible variables related to parent overall satisfaction with the medical visit as well as parent-reported communication satisfaction with care provider communication about weight, diet, and physical activity. A two-tailed Spearman's Rank Order

Correlations revealed a strong, positive correlation between child age and parent-reported satisfaction with the care provider communication, *rho* (30)=.51 p=.004.

Kruskal-Wallace tests elucidated a statistically significant difference in parent satisfaction with care provider communication across the three different visits with care provider groups, $\chi^2(2, n=33) = 8.83$, p=.012 as well as across the 5 categories of time with the care provider, $\chi^2(4, n=33) = 10.25$, p=.037. Parent satisfaction with care provider communication followed a u-shaped curve for both visits with the care provider and time with the care provider.

These findings were used to inform and structure the qualitative analysis in the following ways: As mentioned, child age was included when discussing each conversation analysis transcription excerpt to highlight the role that age may play in parent reported satisfaction. Finally, the quantitative results were used to contextualize and inform each qualitative chapter.

Qualitative Findings

Research questions 1 and 2.

The qualitative findings were guided by research questions one and two. First, "*how do care providers, parents, and children discuss weight, diet, and physical activity in well-child visits?* Second, *in what ways are discussions similar or different between children of normal weight, overweight/obese, or underweight?* These questions were pursued utilizing an analysis that divided the sample by weight category and looked closely at communication within each category—noting differences and similarities between weight groups. Specific findings are outlined below.

Figure outlining major findings for each weight category.

Figure 3 outlines the major qualitative findings for each weight category.

Chapter three: normal weight patients.

First, in the majority of well-child visits with normal weight patients, care providers label the child's identity based on the child's weight status—applying two main types of labeling: labels of perfection and health and labels referencing smallness or thinness. Labeling a child "perfect" and "healthy" based on weight-status risks tying weight with perfectionism and worth—a potentially dangerous implication. Furthermore, when care providers apply labels of smallness and thinness—they again appear to be attempting to reassure the parent and child that the child is healthy. However, the blithe use of potentially stigmatizing labels to reassure, does not fully account for the negative affect these labels may produce, and the fact that smallness and thinness may be dis-preferred identities.[47–49] Second, in the majority of well-child visits with normal weight patients the child is verbally excluded from discussion of diet, physical activity, and weight. The child's exclusion presents a missed relational and educational opportunity. When care providers do directly address the child they also tend to provide education for the child where they take time to explain the meaning of the growth chart and BMI—indicating that directly addressing the child may go hand-in-hand with a commitment to explain and educate the child on their growth using child-appropriate language. Third, in the majority of well-child visits with normal weight patients care providers only minimally discuss physical activity, if at all. In contrast, nearly every well-child visit includes a nutrition discussion—most often in the form of a food inventory. These findings indicate that physical activity is not given adequate attention—especially given its importance to overall health and functioning.

Chapter four: approaching overweight, overweight, and obese patients.

First, and unsurprisingly, care providers do not apply weight-based labels in any of the well-child visits with overweight/obese patients. Information from the growth chart and BMI is

not tied to identity and not used to reassure. Second, care providers appear to take the abstract treatment of weight one step further and engage in *excessive abstraction* when discussing the child's weight status. This includes partially or even fully removing child from weight status. Instead the child's weight is framed as a location or rate—an "it" to be managed. This excessively abstract treatment partially obscures a clear diagnosis. Third, in lieu of a clear communication of the child's weight status, care providers turn to extensive and often paternalistic behavioral counseling about diet and physical activity. In so doing, the full responsibility of the child's weight is placed on parent and child behavior. Potential, and perhaps more fundamental root causes, like adverse childhood experiences, remain unexplored.

Chapter five: approaching underweight and underweight patients.

Overall, care providers treated approaching/underweight patients as liminally healthy—somewhere between healthy and problematic. Underweight patients are not fully accepted or rejected as healthy. First, labels of smallness and thinness are readily applied to the child without accounting for possible stigma. Second, care providers mostly frame and discuss diet as non-problematic. There is no intense behavioral counseling and the discussion mostly progresses as a food inventory. Nonetheless, care providers subtly emphasize iron-intake and other issues particular to underweight. Third, physical activity is not framed as especially relevant, and is not tailored to underweight status.

Key findings taken together: *Stigma and the spoiled identity.*

These findings, taken together, indicate that care providers treat patients quite differently based on the child's weight status. Weight-based labels are applied to both normal weight and underweight patients but not overweight/obese patients. Discussions about diet are present within all weight categories, but with overweight/obese patients this discussion includes counseling and

the implication that improvements are needed. Similarly, approaching/underweight patients are somewhat treated like normal weight patients, but there is also a subtle emphasis on nutritional issues relevant to an underweight status. Physical activity is sometimes briefly mentioned with approaching/underweight and normal weight patients, but with overweight/obese patients it is more emphasized and tied to recommended changes.

Key to these findings is the concept and theory of stigma and the spoiled identity.[44] Goffman (1963) framed stigma as "undesired differentness" [(p5)] that threatens to "spoil" an individual's social identity. Specifically, when society views a person with a visible difference, like overweight status, they may unfairly attribute certain characteristics to that person, whether these attributes are warranted or not (i.e., that overweight children eat too much dessert). The visible difference risks "spoiling" the individual's identity in the eyes of others.

Care providers and parents in the sampled well-child visits appear keenly aware of the stigma surrounding overweight/obese status. Care providers are careful to avoid weight-based labels with overweight/obese patients and use *excessive abstraction* when discussing the child's weight status—to the point of potentially obscuring a clear diagnosis. Yet, despite these efforts, care providers still engage in stigmatizing behaviors with overweight/obese patients. Specifically, rather than clearly stating the child's weight status, care providers imply a high weight status by emphasizing the need for modification in eating and exercise behaviors—implying that the child's weight status is a result of indulgent eating and exercise behaviors. In this way, the care providers assume that the child's stigmatized attribute, overweight/obese status, implies certain unsavory behaviors—neglectful eating and exercise behaviors—whether these attributions are warranted or not, and to the neglect of other possible factors.

Conversely, care providers seem less aware of the stigma surrounding labels of smallness and thinness. With both normal weight and approaching/underweight patients, care providers readily apply labels of smallness and thinness seemingly without awareness to the fact that this might not be a preferred identity for the child.

Limitations and Directions for Future Research

The current study has several limitations, which also elucidate potential avenues for future research. First, the current study included only one pediatric clinic. Although involving only one clinic allowed for a more simple and exploratory focus, it would be interesting to see how the communication patterns identified in the current analysis may be similar or different across variant clinic settings. Furthermore, as mentioned earlier, the participants of the current project were a high-income sample and the study clinic was highly rated by parents. Future projects would benefit from comparing the results with a lower-income sample, and possibly a lower-functioning clinic—to assess how/if communication about diet, physical activity, and weight may be similar or different in a less-resourced setting.

Second, the current sample size of 39 parent/child groups was fairly small for the quantitative analysis component. Although this number provided ample qualitative data, it would be helpful to analyze post-visit questionnaires by weight-group, as this was not possible with a smaller sample size.

Third, the present project did not particularly explicate the role of parent, child, and care provider race, ethnicity, and sex in the qualitative analysis. The parent-reported post-visit questionnaire included parent and child race, ethnicity, and sex, however, these variables were not significantly associated with the outcome variables at the $p<.05$ significance level, and further qualitative analysis of these variables was not prioritized in the current analysis.

However, future work might benefit from more thoroughly examining race, ethnicity, and sex in the analysis. Previous research indicated a difference in care provider patient-centered communication and time spent with the patient based on the sex of the provider—with female care providers engaging in more patient-centered communication and spending longer with patients.[74] It would be interesting to note if there is a difference in how male and female care providers discuss weight, diet, and physical activity issues. Similarly, future work might benefit from an analysis of cultural differences in how diet, physical, activity and weight discussions occur within different ethnic groups. Previous research has examined communication about weight with pediatricians and overweight Latino children and their parents.[11] Future work examining potential similarities and differences in care provider, parent, child communication by racial or ethnic group would help further explicate these previous findings. Furthermore, subsequent examination of these factors may further elucidate and contextualize the current findings.

Fourth, the current project only included audio-recording rather than video-recording, per review board requirements. Viewing and analyzing the embodied interaction of parents, children, and care provider would provide a further layer of depth to the analysis. Video-recordings would allow for analysis of how body language is used when discussing diet, physical, activity and weight. Such analysis could be especially elucidating given that the child's body is the topic of the discussion. For example: How does the child hold his or her body when the care provider discusses overweight status? Does the care provider avoid or maintain eye contact when providing an identity label? In fact, previous conversation analysis work using video-recording to examine communication between care providers and patients has elucidated rich findings (see:

[75])—and a similar approach to pediatric discussions could add valuable insights to the current analysis.

Fifth, the P-MISS-CWDPA assess care provider communication about weight, diet, and physical activity, with weight, diet, and physical activity included together for most items. For example, "*The care provider listened closely to my child talk about weight, diet, and physical activity*." Such item wording potentially masks differences in parent satisfaction with care provider communication on each separate dimension. Specifically, given that care providers only minimally discussed physical activity, it would have been noteworthy to see if/how these items may have been rated differently by parents if weight, diet, and physical activity were measured separately. Future research should further modify the measure so items measure only one dimension at a time.

Sixth, the 39 collected well-child visits included many additional topics that could not be fully addressed. For example, there were many instances in which the care provider, parents, and even the children discussed vaccinations. Although not the focus of the current project, communication about vaccinations in well-child visits would be a rich field for future conversation analytic work.

Additional directions for future work include further assessment of several of the single-case studies included in the collection. Such an analysis would allow for a focused explication of the social actions included in these visits. For example, well-child visits like Pediatrics 24.5, in which the care provider and mother repeat the term "perfect," and Pediatrics 6.7 in which the father insists and defends that his underweight daughter is not a "picky eater," require further analysis.

Clinical Implications and Recommendations

Table 9 outlines several clinical recommendations based on the findings of the current project. The recommendations are divided by child weight category. Each recommendation is discussed in depth in the section to follow:

Table 9: Clinical Recommendations

Normal Weight	**Overweight/Obese**	**Approaching/Underweight**

• Avoid labeling children based on weight-status
  o Potential for stigma
  o Risks perpetuating a dis-preferred identity
• Include children in discussions about weight, diet, and physical activity
  o Using child-friendly language
• More thorough treatment of exercise
	• Clearly communicate that the child's weight is outside the healthy range
	  o Without obscuring through *excessive abstraction*
	  o Without resorting to harsh or stigmatizing language
	• Utilize a team-based strategy like *the Chronic Care Model* to address overweight/obese status and mitigate care provider time constraints
	  o Counselor/Nurse practitioner to fully engage with multi-factor counseling
	  o Exploring diverse and root-causes, and reducing stigma and blame
	  o Linking directly to community resources
		• Avoid labeling children using potentially stigmatizing labels of smallness and thinness
		• More care taken in addressing potential nutritional needs
		• More fully discuss physical activity
		  o Tailor to underweight status

Normal Weight

The finding that care providers readily apply labels of perfection and health as well as labels of smallness and thinness emphasizes the need for care providers to be more careful in how they reassure parents and children, and more aware of the possible negative impacts of blithely applying weight-based labels. Additionally, the finding that several care providers did not provide weight-based labels to normal weight patients, yet, were able to communicate weight status, highlights that it is possible to clearly communicate a child's weight status to parents

without resorting to weight-based labels. Future work would benefit from a more thorough explication of how care providers can clearly communicate weight-status without using weight-based labels.

The finding that care providers often exclude children from discussions about weight, diet, and physical activity elucidates the importance of including children in discussions about their own bodies. This finding also highlights the need to educate care providers on *how* to include children using language the child can understand. Previous work examining care provider and child communication found that when care providers directly addressed children in pediatric visits this promoted physician-child rapport, children's greater preference for an active role in their health care and medical knowledge, and child recall of treatment recommendations.[52] Previous work has also elucidated that children value communication with their care provider—especially having the care provider use language they can understand without medical jargon.[53] Making space for children's voices in well-child visits ought to be a crucial component in care provider training and practice. Care provider communication needs to include strategies to engage children and tailor communication of key health results using child-friendly language.

Lastly, the finding that physical activity is woefully under-emphasized points to the need to assess and encourage this behavior as a healthy habit in its own right—and not just in reference to weight-management. In fact, previous research emphasizes the health benefits of physical activity and its importance to both mental and physical functioning.[55]

Approaching/Overweight/Obese

The finding that care provider communication about weight with overweight/obese patients is excessively abstract to the point of potentially obscuring a clear diagnosis, begs the

question of what the ideal communication with these patients might be. The alternative, overtly and clearly communicating the child's overweight and obese status, could be challenging for both the care provider and the parent and child. Previous research has indicated that trainee care providers prefer euphemism to overt terms like "obese"—and the current findings confirm this tendency.[58] Perhaps the ideal communication of overweight/obese status is found somewhere in middle—between overt labels like "obese" and excessive abstraction that avoids weight-based terms altogether. For example, clearly stating that a child's weight is outside the healthy range, could communicate high-weight, problematic status without using a term like "obese" that could be difficult for both the care provider and parent. Further work is needed to find exemplars of how this communication might occur in interaction and emphasizes the need for further conversation analysis work in this key field.

Furthermore, the finding that, care providers turn to behavioral counseling that frames the child's weight as exclusively a result of diet and physical activity, points to the need for care providers to understand and discuss overweight/obese status as a condition potentially impacted by multiple factors. These factors could include environmental, societal, familial, and genetic causes of high-weight status, as well as adverse childhood experiences.[56,62]

However, a major barrier to discussing and exploring such a wide array of factors related to overweight and obesity could be care provider lack of time and the fact that care providers need to address a vast array of issues in each well-child visit. The goal would be ensuring that there is time to discuss and frame overweight/obesity as originating from multiple possible factors and systematically addressing those factors and providing follow-up options. Public health models like the chronic care model,[76] could point to an approach that balances the need to conserve care provider time while more fully exploring diverse factors related to

overweight/obese status. Specifically, the chronic care model emphasizes the need for a division of labor so that care providers work within a system of care with various highly trained and empowered team members providing different functions (i.e., termed in the model: *health care organization*). Additionally, the chronic care model also emphasizes *community resources and policies* and the importance of cultivating strong ties between the clinic and community resources.[76]

With overweight and obese patients, perhaps care providers could directly lead patients to a counselor, nurse practitioner, or other trained personnel rather than trying to carry the burden of the weight discussion alone. This additional team member could fully explore and discuss the child's weight status, including factors beyond diet and physical activity, and direct and link patients to community resources. Such an approach could provide more time for a nuanced weight discussion and reduce the stigma[44,62] and blame implied by framing weight as solely the result of eating and exercise. Furthermore, framing care providers as crucial advocates for healthy behaviors as well as referrals to outside resources, utilizes the role of care provider as an important component in a multi-factored understanding of health behavior—an approach supported by previous research.[77]

Approaching/Underweight

Overall, in the sampled well child visits, there seemed to be a lack of priority to underweight as a potential health issue. This lack of priority was exemplified in how care providers seemed to take less care when discussing nutritional issues relevant to underweight status, as compared to nutritional issues relevant to overweight status. Specifically, the subtle, inconsistent treatment of iron-deficiency and anemia could be too subtle for parents to understand the need to ensure their lower weight children are receiving adequate nutrition.

Additionally, the finding that care providers readily apply potentially stigmatizing labels of thinness to underweight patients (i.e., "so you're a lean guy") again highlights the fact that care providers may not be aware that these terms are potentially stigmatizing [47–49] and risk promoting a dis-preferred identity.[44] Finally, the scarce treatment of physical activity misses an opportunity for care providers to assess exercise and tailor it in a way that is specific for approaching/underweight patients, taking into consideration issues like bone mineral density, aerobic capacity, and muscle strength.[72]

Appendix: P-MISS-CWDPA Scale

	Strongly Agree	**Agree**	**Agree Somewhat**	**Undecided**	**Disagree Somewhat**	**Disagree**	**Strongly Disagree**
a. The care provider listened carefully to what I said about my child's weight, diet, and physical activity							
b. The care provider did not really give me a chance to speak about my child's weight, diet, and physical activity							
c. I felt understood by the care provider when discussing my child's weight, diet, and physical activity							
d. The care provider did not appear to understand my reason for discussing my child's weight, diet, and physical activity.							
e. The care provider gave a poor explanation of my child's weight and/or diet, and physical activity.							
f. The care provider seemed to have other things on his/her mind.							
g. The care provider talked to my child about what (s)he can do to eat healthfully and/or exercise.							
h. The care provider seemed to think it was important for my child to understand, weight, diet, and physical activity.							
i. The care provider encouraged my child to talk about weight, diet, and physical activity.							
j. The care provider listened closely to my child talk about weight, diet, and physical activity.							
k. The care provider knows how to talk to children about weight, diet, and physical activity.							
l. The care provider used words too difficult for the child to understand when discussing weight, diet, or physical activity.							

	Strongly Agree	Agree	Agree Somewhat	Undecided	Disagree Somewhat	Disagree	Strongly Disagree
m. The care provider really understood how the child feels about weight, diet, and physical activity.							
n. The care provider explained weight, diet, and physical activity very well to my child.							
o. The care provider excluded my child from most of the discussions of weight, diet, and physical activity.							
p. My child could not understand most of what the care provider said about weight, diet, and physical activity.							
q. The care provider seemed to think about my child's weight, diet, and physical activity carefully.							

Note: Adapted from P-MISS Scale[28]

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