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Family Fat Talk Questionnaire – Polish adaptation

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Summary

Aim. One of the dangerous phenomena that reinforces a negative attitude towards one's own body is the so-called family fat talk[1], i.e. conversations initiated by carers/siblings self-devaluing body shapes and sizes. The aim of our own research was to adapt the self-report two-factor tool Family Fat Talk Questionnaire (FFTQ) by MacDonald et al., which may be used in the prophylaxis of maladaptive behaviours towards eating and the body, especially in the adolescent population.

Method. The study covered 391 people at the turn of late adolescence and early adulthood. The following were used: (1) personal questionnaire – to control secondary variables (e.g. gender, BMI, difference between the actual and desired body weight), (2) Family Fat Talk Questionnaire in the Polish language version (FFTQ-PL) and (3) *Kwestionariusz wizerunku ciała* (KWCO) by A. Głębocka to check external accuracy.

Results. The research results indicate that the FFTQ-PL has satisfactory reliability and measurement accuracy, and its two-factor structure (factor 1 – "I"; factor 2 – "Family") has been confirmed.

Conclusions. This measure is worth using in screening studies to identify people – especially adolescents – engaging in self-devaluing conversations within the family. It turns out that fat talk, especially in the case of people with a negative body image, can become a risk factor for risky eating practices.

Key words: fat talk, family, eating disorders

[1] Polish works on fat talk use only the English name of the phenomenon.

Introduction and aim of the work

The body is a domain of human functioning that is related to physical fitness, health, as well as personal identity, self-esteem and attractiveness [1]. Acceptance of one's body image is particularly important during adolescence, a stage characterised by intense physical changes and a simultaneous significant susceptibility of young people seeking their own identity to the influence of the socio-cultural environment [2]. Meanwhile, contemporary and often unrealistic aesthetic ideals regarding female and male bodies are a source of frustration for many teenagers, which results in lowering their self-esteem.

The main correlate of the beauty ideal, regardless of gender, is the proportion and distribution of adipose and muscle tissue in the total body weight. At the times of the overweight and obesity epidemic, we are faced with fat phobia[2] [3] and fat shaming[3] [4], and a concern about body weight is manifested in fat talk, which consists in discrediting the shape and weight of one's own or other people's body [5]. Importantly, fat talk is not about 'being fat' but about 'feeling fat' [6], and thus can occur among people with both high and low body weight. In addition to statements such as 'I am (too) fat', 'I have fat thighs', 'my belly is like a balloon', 'my arms are too flabby', fat talk also includes comments about improving physical appearance, changing eating habits and physical activity as well as the fear of being overweight [7].

This phenomenon was considered to be normative, especially in the female population, regardless of age. However, researchers indicate that conversations about the body and weight are most often conducted by girls in late adolescence and women in early adulthood [6, 8]. Moreover, it seems that along with socio-cultural changes, fat talk is gaining popularity among boys and men, although the content of their conversations differs slightly from those of women [9, 10].

At the same time, it is indicated that fat talk may already occur in the family environment, contributing to the development of children's dissatisfaction with their bodies and their refusal to eat or overeating [11]. In such families, especially mothers model behaviours aimed at monitoring and modifying the body to conform with the aesthetic standards which enable to maintain one's own value in society. It starts at the young age and regards mainly daughters [12]. Negative comments from both parents and siblings about the child's appearance are also associated with radical diets, low self-esteem, depressive mood, symptoms of eating disorders and body dissatisfaction [13]. The last, however, is a predictor of involvement in fat talk [14] and the most common strategy of coping with disapproval of one's own image in overweight and obese people [12]. At the same time, according to Nichter [15], verbalising dissatisfaction with the body during a conversation can be a valve for the outlet of negative emotions, and according to Gapinski et al. [16], it alleviates discomfort through positive

[2] Fear of eating fat and fatness of one's own body and reluctance towards people with obesity.

[3] Shaming people with excessive body weight by the environment.

reactions of peers (usually in the form of denial of comments made by a given person that self-devalue his or her own physicality).

Researchers are also investigating the functions fat talk can play in people with a positive body image [17]. It turns out that starting such conversations, e.g. when trying on clothes, undressing on the beach or at the swimming pool helps to establish relationships with peers, maintains social bond by expressing related thoughts and values, and facilitates experiencing and offering social support [16]. Additionally, discussions on body weight and appearance, as a normative social behaviour in a culture that values thinness, enable participants to convince other people that despite their physical attractiveness, they are not superior [7]. For example, Britton and his team [18] found that not engaging in fat talk is sometimes interpreted by peers as arrogance, which increases the risk of social exclusion of those who do not participate in such conversations. Interestingly, it has been found that talking about one's body in a positive way can be more socially attractive than engaging in its public disparagement. Barwick et al. [19] noted that the subjects assessed women who spoke positively about their bodies as more likeable, even if the others engaged in fat talk. In this way, participants who use a favourable narrative towards their own physicality in a conversation can become a positive model of self-acceptance for discussion partners who present fat talk [20].

Our research aimed to adapt the *Family Fat Talk Questionnaire* (FFTQ) by MacDonald et al. [21]. The authors of the article suggest that this tool can be used as a prophylactic screening measure in order to prevent eating disorders and other adverse effects of fat talk, primarily in the adolescents. The analysis of literature sources indicates that although such conversations are a socially accepted form of naming and expressing negative emotions related to the body and an important element of peer relationships [22], they are also one of the risk factors for developing an incorrect attitude to food and strengthening dissatisfaction with the body, especially in adolescents [13].

Furthermore, the authors' intention was to answer the question whether secondary variables (e.g. BMI, difference between real and ideal body weight, gender) are related to the intensity of fat talk in the study sample.

Material and method

Prior to conducting our own research, the authors of the *Family Fat Talk Questionnaire* (FFTQ) [21] were asked for their consent to its cultural adaptation and validation. After receiving the consent: (1) the Polish version of the tool was prepared, (2) an English teacher made a reverse translation, (3) the translation of the questionnaire was compared with its original version, (4) the Polish version of the tool was finally adopted on the basis of its consistency with the original version.

Subsequently, a personal questionnaire was developed to collect the necessary information about the study participants (including gender, age, height, real and ideal

body weight). In addition, the *Kwestionariusz Wizerunku Ciała* (KWCO) tool [23] was selected to verify the measurement accuracy of the FFTQ-PL.

The research project was carried out online from December 2022 to February 2023 on a sample of 391 people at the turn of late adolescence and early adulthood, i.e. from 18 to 35 years old. Purposive sampling was used, with age as the criterion for inclusion in the sample. Finally, the data collected from 375 participants were included in the analyses because the rest were incomplete or did not meet the inclusion criterion (i.e. age within the indicated range). The entire sample consisted of 123 men (32.8%), 246 women (65.6%), and 6 respondents (1.6%) who identified their gender as 'different'. The overrepresentation of women in the research sample is probably due to the fact that women are more willing to participate in research projects, as well as in the fields of study represented by the project participants (psychology, pedagogy, physical culture, dietetics). The average age of both men and women was 22 years while of the remaining participants – 20 years. Out of all participants, 159 study, 173 study and work simultaneously, 42 only work, and one neither studies nor works.

The average BMI[4] value in the sample is 23.12, which indicates normal weight. In the subgroup of women, 68.7% have normal body mass, 6.5% are obese, 14.2% are overweight, and 10.6% have reduced body mass. In the group of men, the BMI value indicates 62.6% of people with normal weight, 3.2% with obesity, 29.3% overweight, and 4.9% with reduced body weight. Half of the people describing their gender as 'different' had normal body weight, 33.3% were overweight and 16.7% were underweight.

The difference between the current and ideal (desired) body weight indicated by the respondents was the largest (11.5 kg) in people describing their gender as 'other', in women it was 6 kg, and in men it was 1.5 kg. In the case of the first two subgroups of the study, the current body weight was higher than expected, while in men – the opposite. The surveyed participants reported that they use various forms of weight control, including 253 people engaging in physical activity, 128 using a reduction diet without the supervision of a specialist, 20 – receiving care from a dietician, and 43 taking dietary supplements and 'fat burners', while 85 people declared that they do not control their weight either using the indicated methods or any other methods.

Nearly 62% of the respondents assessed their mental functioning as good, slightly above 12% – very good, 20% – as rather bad, and the rest (6%) – very bad. About 12% of the respondents regularly take medication due to problems in mental functioning. In turn, more than half of the participants described their somatic health as good, 27% as very good, about 19% considered it bad, and the rest – very bad. Due to their somatic health, more than 15% of the respondents use pharmacotherapy for medical indications.

The project was prepared and implemented with due attention to the highest ethical standards. The respondents were informed about the purpose of the research, its

[4] Reference indices for BMI: below 16.0 – starvation, from 16.0 to 16.99 – emaciation, from 17.0 to 18.49 –underweight, from 18.5 to 24.99 – normal weight, from 25.0 to 29.9 – overweight, above 30.0 – obesity.

voluntariness, their right to discontinue their participation at any time without giving a reason, confidentiality, and gave their informed consent. They were required to complete a personal questionnaire and two additional questionnaires with an average examination time of 10 minutes.

The *Family Fat Talk Questionnaire* (FFTQ) consists of 16 items. Their original number was reduced by its authors from 28 as a result of statistical analyses [21] (Table 1). The respondent refers to each of the items by specifying on a scale of 1-5 (1 – never, 2 – rarely, 3 – occasionally, 4 – very often, 5 – always) to what extent it describes him/her and his/her family. The maximum score that can be obtained in the questionnaire is 80 and the minimum is 16.

Table 1. **Family Fat Talk Questionnaire – original and Polish version**

Original version – FFTQ	**Polish version – FFTQ-PL**
When I'm with my family members, I complain that my arms are too flabby.	Kiedy jestem z rodziną, narzekam, że mam zbyt zwiotczałe ramiona.
When I'm with my family members, I complain that my body is out of proportion.	Kiedy jestem z członkami rodziny, narzekam, że moje ciało jest nieproporcjonalne.
When I'm with my family, I complain that I am fat.	Kiedy jestem z rodziną narzekam, że jestem gruba.
When I'm with my family, I complain that I should not be eating fattening foods.	Kiedy jestem z rodziną, narzekam, że nie powinnam jeść tuczących pokarmów.
When I'm with my family, I complain that my clothes are too tight.	Kiedy jestem z rodziną, narzekam, że moje ubrania są za ciasne.
I criticize my body compared to my family members' bodies.	Krytykuję swoje ciało w porównaniu z ciałami członków mojej rodziny.
When I'm with my family members, I complain that I feel pressure to be thin.	Kiedy jestem z członkami rodziny, narzekam, że czuję presję, by być szczupłym.
When I'm with my family members, I complain that I'm not in shape.	Kiedy jestem z członkami rodziny, narzekam, że nie jestem w dobrej formie fizycznej.
When I'm with my family members, I hear them complain that their arms are too flabby.	Kiedy jestem z członkami rodziny, słyszę, jak narzekają, że mają zbyt zwiotczałe ramiona.
When I'm with my family, I hear them complain about the proportion of their bodies.	Kiedy jestem z rodziną, słyszę, jak narzekają na proporcje ich ciał.
When I'm with my family, I hear them complain that they are fat.	Kiedy jestem z rodziną, słyszę, jak narzekają, że są grubi.
When I'm with my family, I hear them complaining that they should not be eating fattening foods.	Kiedy jestem z rodziną, słyszę, jak narzekają, że nie powinni jeść pokarmów tuczących.
When I'm with my family, I hear others complain that their clothes are too tight.	Kiedy jestem z członkami rodziny, słyszę, jak narzekają, że ich ubrania są za ciasne.
When I'm with my family members, I hear them criticize their bodies compared to their family members' bodies.	Kiedy jestem z członkami mojej rodziny, słyszę, jak krytykują swoje ciała w porównaniu z ciałami innych członków rodziny.

table continued on the next page

When I'm with my family members, I hear them pressure each other to be thin.	Kiedy jestem z członkami rodziny, słyszę, jak naciskają na siebie, by być szczupłym.
When I'm with my family members, I hear others complain that they are not in shape.	Kiedy jestem z członkami rodziny, słyszę, jak narzekają, że nie są w dobrej formie fizycznej.

Two subscales were distinguished in the *Family Fat Talk Questionnaire*, ('I' – the self-esteem of the subject's attitude towards their own body; 'Family' – the subject's perception of the behaviour of the closest people towards the body), which was indicated by the exploratory factor analysis. Each of them is characterised by strong internal coherence. The reliability of the tool in the original studies, measured by the Cronbach's alpha, was 0.90 in total, 0.88 for the 'I' subscale, and 0.89 for the 'Family' subscale [21]. In our own research these values were: 0.89, 0.85 and 0.91, respectively; therefore, they are satisfactory.

In addition to completing the FFTQ-PL questionnaire, the respondents were asked to refer on a scale (*definitely yes, rather yes, hard to say, rather no, definitely not*) to three issues: (1) I am too fat; (2) I feel attractive; (3) The way I think about my body results from the way my loved ones approached the body.

Kwestionariusz Wizerunku Ciała (KWCO) [23] is a factorial tool consisting of 40 items that make up four 10-item subscales: (1) 'cognition – emotions' CE (to measure opinions about one's appearance), (2) 'behaviour' B (refers to a healthy lifestyle), (3) 'environmental criticism' EC (allows to determine the subjective level of acceptance by the environment) and (4) 'pretty-ugly stereotype' PU (measures the degree of internalisation of contemporary standards of beauty). KWCO is the first measure in Poland designed for people experiencing psychosocial problems which are clearly related to body shape and weight [23]. The task of the examined person is to refer to subsequent statements on a 5-point scale (*1 – definitely not, 2 – rather not, 3 – hard to say, 4 – rather yes, 5 – definitely yes*). The maximum score that can be obtained in the questionnaire is 200 and the minimum is 40.

The reliability of the tool, expressed by the Cronbach's alpha coefficient, is 0.93 in total, for the subscale CE – 0.93, B – 0.83, EC – 0.67, and PU – 0.88 [23]. In our own research, these values were respectively: 0.86, 0.88, 0.47. and 0.87. In general, they are satisfactory, although both in the original and own research, the reliability of the 'environmental criticism' subscale is lower than 0.70. Despite this, it was decided to include all results in the analyses.

Results

The analyses began with performing descriptive statistics for the FFTQ-PL (Table 2).

Table 2. **Descriptive statistics for FFTQ-PL**

	Min.	Mean	Max.	Std dev.	Skewness	Kurtosis
FFTQ-PL	32.912	16	68	11.645	0.614	-0.345
Family	18.669	8	39	7.861	1.153	0.740
I	14.243	8	36	6.091	0.437	-0.837

The maximum sum of points in the FFTQ-PL in the sample was 68, the minimum was 16, and the average was 33. In terms of the 'Family' factor, the maximum score was 39, the minimum was 8, and the average was 19, while for the 'I' factor it was 36, 8 and 14, respectively.

Subsequently, the factor structure of the tool was verified using, the Oblimin principal factor extraction method with Kaiser normalisation. Partial correlation coefficients were also checked (Table 3).

Table 3. **FFTQ-PL structure matrix with Kaiser-Meyer-Olkin rotation**

	Factor 1	Factor 2	Uniq	MSA
FFTQ11	0.898		0.199	0.892
FFTQ14	0.818		0.337	0.919
FFTQ12	0.814		0.362	0.938
FFTQ10	0.794		0.384	0.902
FFTQ13	0.754		0.392	0.935
FFTQ15	0.729		0.461	0.927
FFTQ16	0.693		0.507	0.926
FFTQ9	0.499		0.709	0.913
FFTQ3		0.843	0.329	0.834
FFTQ4		0.705	0.507	0.892
FFTQ6		0.670	0.538	0.883
FFTQ7		0.651	0.559	0.884
FFTQ2		0.648	0.564	0.876
FFTQ8		0.589	0.635	0.898
FFTQ5		0.537	0.669	0.911
FFTQ1		0.348	0.856	0.866

The conducted analysis confirms the original structure of the tool. In the studies of MacDonald et al. [21], it was verified by confirmatory factor analysis (for $N = 174$)

which enabled the authors to distinguish two subscales: 'I' (1-8) and 'Family' (9-16). Our own research ($N = 375$) also showed a two-factor construction of the tool, which is indicated by the values of R^2 (0-1), enabling the recognition of a good fit of the model.

Eventually, in order to re-test the factor structure of the FFTQ-PL, modeling of structural equations was performed, again proving the presence of two subscales – 'I' and 'Family' (Figure 1, Table 4).

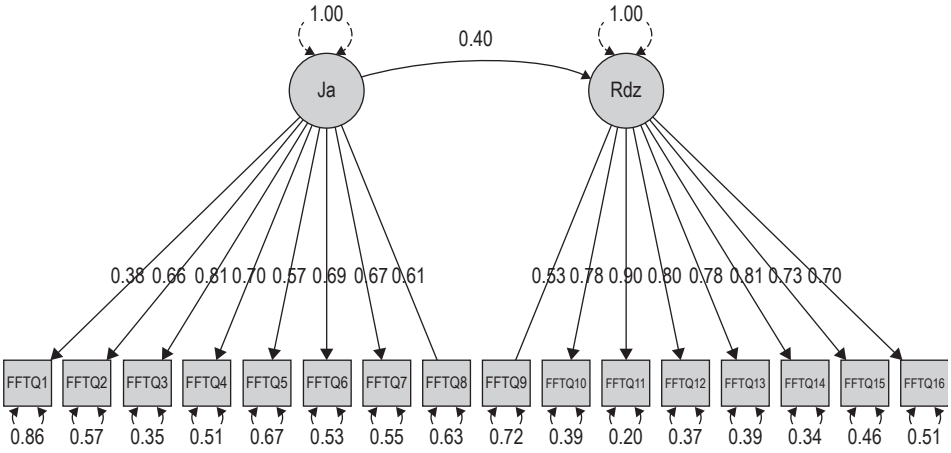

Figure 1. **Structural equation modeling for FFTQ-PL**

Factor 'Ja – I'; Factor 'Rdz – Family'

Table 4. **Chi-square test**

Chi-square test: Factor model	**X^2**	**df**	**p**
	287.010	103	<0.001
CFI	0.937		
TLI	0.927		
RMSEA	0.069		
RMSEA 90% CI lower bound	0.060		
RMSEA 90% CI upper bound	0.079		
SRMR	0.044		

Then, the correlations between the FFTQ-PL and the KWCO were checked, both in terms of the total sum of points and the results in the subsequent subscales of both tools (Table 5).

Table 5. **FFTQ-PL and KWCO correlations**

	Mean	Std dev.	FFTQ	Family	I	KWCO	CE	B	EC	PU
FFTQ	32.912	11.645	1.000	0.876*	0.782*	0.571*	0.638*	-0.249*	0.348*	0.275*
Family	18.669	7.861	0.876*	1.000	0.383*	0.376*	0.390*	-0.175*	0.267*	0.218*
I	14.243	6.091	0.782*	0.383*	1.000	0.606*	0.716*	-0.251*	0.320*	0.244*
KWCO	115.203	20.302	0.571*	0.376*	0.606*	1.000	0.836*	-0.017	0.791*	0.435*
CE	40.403	13.808	0.638*	0.390*	0.716*	0.836*	1.000	-0.366*	0.454*	0.278*
B	17.317	5.456	-0.249*	-0.175*	-0.251*	-0.017	-0.366*	1.000	-0.073	-0.017
PU	42.907	9.526	0.348*	0.267*	0.320*	0.791*	0.454*	-0.073	1.000	0.216*
EC	14.576	3.019	0.275*	0.218*	0.244*	0.435*	0.278*	-0.017	0.216*	1.000

* $p < 0.05$

FFTQ subscales: Family, I

KWCO subscales: CE – 'cognition-emotions'; B – 'behaviour'; EC – 'environmental criticism'; PU – 'pretty-ugly stereotype'

The analysis of the collected material shows that there are statistically significant correlations between both the FFTQ-PL and the total KWCO, as well as between the factors included in both tools. The FFTQ-PL sum correlates with all KWCO factors, and the KWCO sum has a significant relationship with both FFTQ-PL subscales. It is noteworthy that among the significant correlations, one is negative. This concerns the relationship between the FFTQ-PL sum and the KWCO subscale – 'behaviour'. This means that the greater the intensity of the symptoms of family fat talk, both in total and separately – in relation to the 'I' and 'Family' subscales, the lower the intensity of behaviours related to a healthy lifestyle. Therefore, it can be concluded that the measurement accuracy of the FFTQ-PL is satisfactory.

Additionally, correlations between secondary variables and family fat talk scores were tested (Table 6).

Table 6. **FFTQ-PL correlations with secondary variables**

	R-I	BMI	F	A	BT
FFTQ-PL	-0.313*	0.175*	0.416*	-0.281*	0.339*
Family	-0.196*	0.098	0.176*	-0.133*	0.284*
I	-0.346*	0.207*	0.568*	-0.366*	0.283*

* $p < 0.05$

FFTQ subscales: Family, I

R-I – difference between real and ideal body weight; BMI – body mass index value; F – 'I am too fat'; A – 'I feel attractive'; BT – 'The way I think about my body is due to the way my loved ones approached the body'

The analysis of the results shows statistically significant correlations (except for the relationship between BMI and the 'Family' subscale) between family fat talk and secondary variables. Importantly, some of the correlations are negative. It turns out that: (a) the greater the difference between the real and ideal body weight of the subjects, the higher the overall result and the partial results of the FFTQ-PL; (b) the higher the BMI value in the sample, the higher the overall result in family fat talk, as well as in the 'I' subscale; (c) the greater the subjective feeling of being fat and the lower the sense of attractiveness of the study participants, the greater their involvement in family fat talk, expressed both in the sum of the FFTQ-PL and in the score for both factors; (d) the greater the respondents feel that their relatives have a share in how they perceive their bodies, the greater the intensity of their involvement in family fat talk in the global dimension, as well as in the 'I' and 'Family' subscales.

Differences in FFTQ-PL results based on the gender of the respondents were also analysed and compared in three groups: women, men and other gender. The Kruskal-Wallis test showed statistically significant differences in the overall FFTQ-PL score and the 'I' and 'Family' factors ($p = 0.000$). Men show significant statistical differences in FFTQ-PL results and the 'Family' subscale compared to women and people identifying as 'other gender' ($p < 0.05$). There are statistically significant differences in the 'I' subscale in the results obtained by women and men ($p < 0.05$) (Table 7). Due to the small size of the subgroup defined as 'other gender', an additional comparison of the results obtained in the group of women and men was made. The intensity of family fat talk is greater among women (Table 8).

Table 7. **FFTQ-PL results by gender**

	FFTQ-PL Kruskal-Wallis test: H (2, N = 375) = 38.39538 p = 0.0000			**I** Kruskal-Wallis test: H (2, N = 375) = 36.49165 p = 0.0000			**Family** Kruskal-Wallis test: H (2, N = 375) = 22.63573 p = 0.0000		
	W R:209.94	M R:139.81	O R:276.17	W R:210.57	M R:140.15	O R:243.50	W R:203.26	M R:152.79	O R:284.25
W		0.000*	0.418		0.000*	1.000		0.000*	0.217
M	0.000*		0.008*	0.000*		0.068	0.000*		0.011*
O	0.418	0.008*		1.000	0.068		0.217	0.011*	

W – women, M – men, O – other

* $p < 0.05$

Table 8. **Comparison of FFTQ-PL results in groups of women and men**

	Mean W	Mean M	t	df	p	W	M	Std dev. W	Std dev. M	F	p
FFTQ-PL	35.220*	27.748*	6.166*	367	0.000	246	123	11.839*	8.982*	1.737*	0.001
Family	19.740*	16.146*	4.270*	367	0.000	246	123	7.898*	7.032*	1.261*	0.150
I	15.480*	11.602*	6.068*	367	0.000	246	123	6.505*	3.973*	2.681*	0.000

W – women, M – men

* $p < .05$

Discussion

The phenomenon of body self-deprecation is common among adolescents and young adults, particularly influenced by culture and family relationships, especially the mother-daughter dynamic [24, 25]. In our own research, 43% of the sample (163 people; $N = 375$) showed above-average results (>32.91) in terms of family fat talk measured by FFTQ-PL, including 24% of men (30 people, $N = 123$), women – 53% (130 people, $N = 246$), and respondents describing their gender as 'other' – 67% (4 people, $N = 6$).

Fat talk, as a normative social behaviour, appears among people with a positive attitude towards their own body. However, in the case of those who do not accept their own image, it is sometimes – but not always – a predictor of increased focus on fat and disturbed eating [26-28]. Consistent with previous research, our own study determined significant correlations between the FFTQ-PL score and: (a) BMI, (b) disproportion between real and ideal body weight, (c) feeling of being fat, (d) feeling of being unattractive, and (e) belief that one's own body image results from how corporeality is perceived by the family and relatives of the examined person.

Additionally, in our own research project, statistically significant relationships were found between family fat talk and the results in the perception of one's own image as measured by KWCO. It has been empirically confirmed that a higher FFTQ-PL score was associated with (a) a more negative opinion about one's appearance, (b) a greater subjective sense of criticism of the environment, (c) a higher level of internalisation of contemporary standards of beauty, and (d) less adherence of a person's behaviour to a healthy lifestyle.

These results are in line with previous findings of other researchers. For example: Barbeau and her team [29] proved that there are connections between how a person's family and peers talk about a person's body and that person's self-perception. Moreover, it has been shown that the greater the intensity of fat talk, the less compassion for oneself and the greater the level of fear of negative evaluation from others. Additionally, other studies [26] verified the correlations between fat talk in the mother-daughter relationship and body dissatisfaction and symptoms of disordered eating in the daughter. It was shown that the relationship between fat

talk and dissatisfaction with the image varied depending on body weight (specifically the normal weight and underweight) of the daughter. In this group, talking negatively about the body in the mother-daughter relationship was associated with greater dissatisfaction with one's appearance. However, no such association has been demonstrated for adolescents with obesity. Meanwhile, Takamura et al. [30] showed that family fat talk mediates between the internalisation of the ideal of a slim body and body dissatisfaction.

Conclusions

The implementation of the own research project allows for the formulation of the following conclusions:

- the two-factor structure of the FFTQ-PL was confirmed, its satisfactory reliability and measurement accuracy were demonstrated;
- it was noted that the intensity of family fat talk is higher among women than among men; (the highest score in the FFTQ-PL was obtained by persons identifying themselves as 'other sex'; however, due to the small size of this subgroup, this observation should be treated with great caution);
- it has been found that a high score on family fat talk coexists with a high BMI, with a greater difference in real and ideal body weight, with a greater sense of being fat, a lower sense of attractiveness and a greater belief that thinking about one's own body results from the attitude of family and relatives to corporeality;
- the FFTQ-PL measure can be used as a screening tool to identify people engaged in this type of self-deprecating conversations under the influence of family and loved ones, which may increase the risk of disturbed attitude towards the body and nutrition.

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