

## Original Article

# Psychometric Evaluation Study of the Health and Weight Attitude Scale in Türkiye

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## Abstract

**Objective:** This research was conducted to evaluate the validity and reliability of determining health and weight attitudes in adult individuals.

**Methods:** This research was conducted to psychometric evaluation for reliability and validity at health and weight attitude scale. The research, adults' participants in an urban area were included, and the study was completed with a total of 502 participants. In the validity and reliability analyses of the scale, firstly its structural validity was examined. For the structural validity of the scale, respectively; Kaiser-Meyer-Olkin and Bartlett Test were used. The scale: It was evaluated with a slope-plateau plot to evaluate the factor structure and item-total correlation and Cronbach ( $\alpha$ ) reliability coefficients to evaluate its reliability.

**Results:** When the findings of the research were examined, a three-factor structure was obtained. Factor structures by the researcher team; It has been conceptualized based on theoretical knowledge as "Perceived Weight and Health Management", "Perceived Weight and Health Relationship", "Perceived Weight and Physical Acceptance". The Cronbach Alpha internal consistency coefficients of the scale are sub-scale respectively 0.775, 0.787, 0.749 and the total Cronbach Alpha value of the scale is 0.785. has been found.

**Conclusion:** It was found that the Health and Weight Attitude Scale is a valid and reliable measurement tool in adult's people.

**Keywords:** Adult, health and weight management, scale reliability and validity, perceived weight, psychometric properties, scale adaptation

## Introduction

Although the World Health Organization (WHO) defines health as not merely the absence of disease and disability, but as a state of complete physical, social, and spiritual well-being, recent studies have revealed a multidimensional relationship between the concept of health and social determinants (WHO, 2025). The subjective well-being of an individual's health can be expressed as the individual's self-evaluation of their physical

and emotional well-being (Regan *et al.*, 2022). In addition to variations in subjective well-being among individuals, the perceived health level of each person also varies. These differences are influenced by sociodemographic characteristics (Rahman *et al.*, 2022; Shaheen *et al.*, 2020), as well as by the relationship between perceived weight and health (Dey *et al.*, 2019; Drake and Ogletree, 2018). An individual's perceived health encompasses A review of the

literature in our country reveals that while the health and weight attitudes of individuals have been examined, no scale has been adapted or developed for this purpose (Kafkas and Ozen, 2014; Esin and Akgul, 2022; Carkit et al., 2025). The global burden of disease is affected by unhealthy nutrition, extreme weight (whether excessive or insufficient), and the desire to be thin. It is hypothesized that determining the health and weight perceptions of individuals in our country will contribute to understanding health perceptions in overweight, obese, or very thin individuals.

**MethodsResearch Design:** This research was conducted to psychometric evaluation for reliability and validity at health and weight attitude scale. The psychometric variety of factors, including gender, mental state (such as stress level), physical activity, and dietary adherence (Denche-Zamorano et al., 2023). Additionally, it includes weight, BMI (Hsu and Chiang, 2020), and perceived weight (Ozturk and Ozturk Haney, 2020). These factors are considered influential. The BMI is calculated to assess the normal weight range recommended for an individual's health. Being underweight, overweight, or obese can lead to various physical health issues (Hoteit et al., 2022), and its emotional and cognitive effects can ultimately have a negative impact on mental health (McCormack and Pamarthi, 2019). It has been demonstrated that weight perception among adolescents in Southern California plays a significant role in shaping the content of educational programs related to body mass index, physical activity, and food choices for both adolescents with normal weight and those who are obese (Gaylis et al., 2020). The Evaluation process of the Health and Weight Attitude Scale is shown in Figure 1.

**Participants and Sample:** The research area consisted of a working group covering approximately 40 neighbourhoods in the central district of centre province and 28 Family Health Centres. Participants were randomly selected, and the data collection process was conducted accordingly. The study's data were collected through a face-to-face survey by the researcher between October 2022 and April 2023. A sample size of 500 participants is generally recommended

in scale adaptation or development studies. This status is considered a "good" level for conducting factor analysis (Boateng et al., 2018; Comrey and Lee, 2013). The study was completed with 502 adult volunteers aged 18-65.

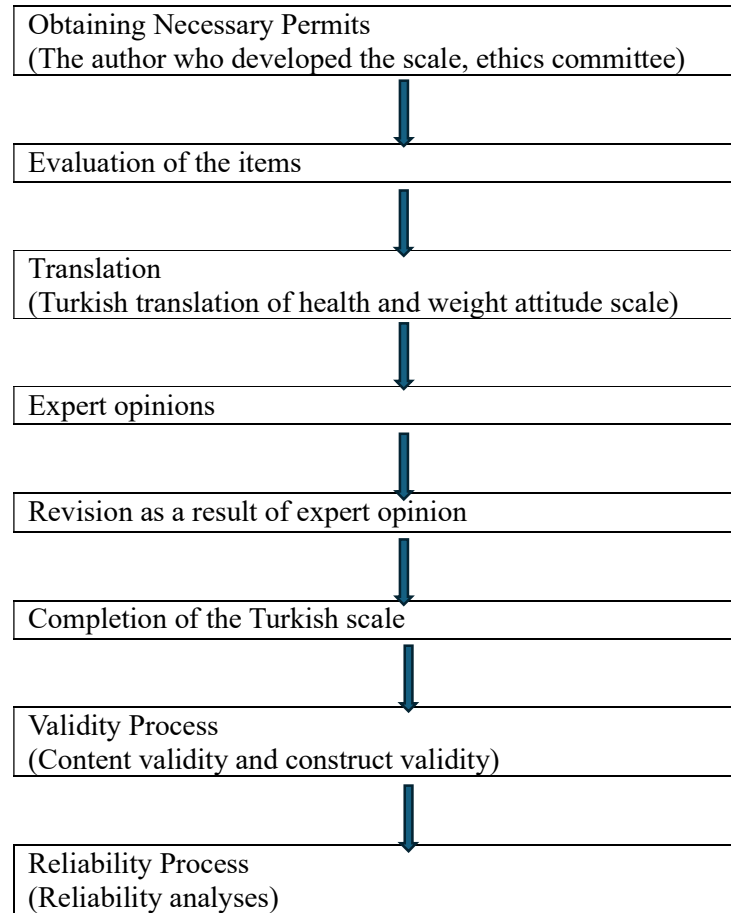
**Questionnaire:** The study's data collection involved two distinct components: socio-demographic characteristics and the Health and Weight Attitude Scale. The socio-demographic characteristics section included six questions related to the individual's gender, marital status, age, educational level, source of economic income, and body mass index.

The Health and Weight Attitude Scale; The scale was developed by Drake and Ogletree (2018). The Health and Weight Attitude Scale is designed to assess an individual's attitudes towards health principles across various dimensions. The original measurement tool demonstrated a Cronbach's  $\alpha$  of 0.75 in the pre-test and 0.78 in the post-test, with a Pearson correlation of 0.85. Original scale form total item includes 21 likert-scale items and six open-ended questions. reliability and validity analysis and one item deleted. The scale consists of 20 Likert-scale items and six open-ended questions, organized into five sub-dimensions. Likert-type items were coded as -2, -1, 0, 1, and 2 for strongly disagree, disagree, neutral, agree, and strongly agree, respectively. Five sub-dimensions were named "Multidimensional health", "Health can be achieved at all size", "non-diet approach to eating for well-being", "Enjoyable, life-enhancing physical activity", and "Size acceptance" (Drake and Ogletree, 2018). In this study, six open-ended questions were excluded, and validity and reliability were evaluated using 20 Likert-type items. New sub-dimensions and names were created based on the findings of the study. The previously included open-ended questions were not used in this study because they were designed in accordance with the structure of the five-dimensional scale developed by Drake and Ogletree (2018).

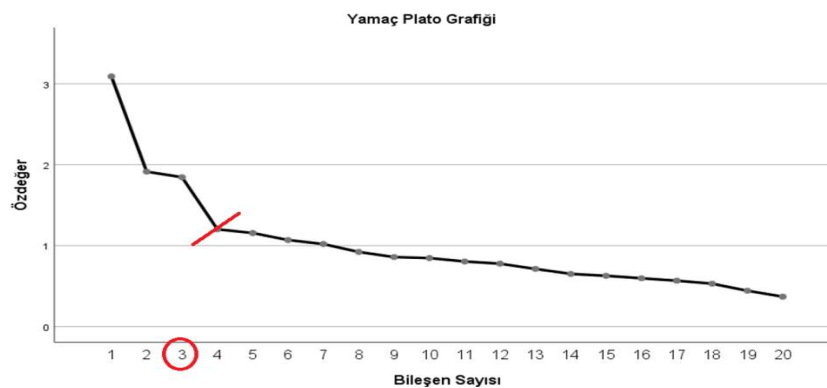
**Research Steps:** According to International Test Commission, there are six categories. The first section named "Pre-Condition" highlights the fact that decisions have to be made before the translation/adaptation process ever begins. The second section "Test Development Guidelines" is focused on the

actual process of adapting a test. The third section "Confirmation" includes those guidelines associated with the compilation of empirical evidence to address the equivalence, reliability and validity of a test in multiple languages and cultures. The final

three sections are related to "Administration", "Score Scales and Interpretation", and "Documentation" (Bartram et al., 2018).



**Figure 1. Scale Adaptation Process**



**Figure 2. Slope Plateau Graph**

**Pre-condition:** The first step in the translation process involved permission by Drake and Ogletree (2018) for usability of scale items. The first step in the translation process involved translating the scale into Turkish. This was done independently by three researchers and one translator fluent in both English and Turkish. The translator was a health professional knowledgeable about both cultures but not informed about the study's subject to ensure objectivity. The translation process continued with the creation of two separate translation forms by two independent researchers and translators. Following this, the research team formulated a preliminary draft to identify and address any semantic, experiential, conceptual, linguistic, and contextual discrepancies. Semantic Explanations. In this phase, the language was adapted to align with Turkish cultural norms.

**Test development guidelines:** The research team finalized the draft form, ensuring that the content resonated with Turkish society by using appropriate language and selecting suitable synonyms or similar words. Expert Panel. In this step, the instrument was sent to eight experts proficient in English and Turkish, including six lecturers in public health nursing, one lecturer in nursing, and one nutrition and dietetics specialist. The experts were asked to evaluate each scale item using a four-point Likert scale with the following options: 1: Significant changes required (in line with my initial suggestions), 2: Moderate changes required (in line with my initial suggestions), 3: Satisfactory, and 4: Highly satisfactory. The degree of agreement among the experts was calculated using the Content Validity Index (CVI), which was determined by dividing the number of experts who rated an item as 3 or 4 by the total number of experts. To ensure content validity, a minimum CVI score of 0.75 is required, as recommended by Lawshe (1975). In the draft form, the Item-CVI (I-CVI) values ranged from 0.50 to 1.00. Items 11, 21, 22, 23, and 24 received an I-CVI score of 0.50. Based on these results, the researchers made the necessary adjustments to these items in accordance with the expert feedback. In this stage, the draft form created according to expert opinions is back translated, and the final version is translated into the native language. The compatibility of the back-translated scale with the original scale was

evaluated by the research team, an independent researcher fluent in both languages, and an individual capable of completing the survey.

**Confirmatory factor analysis:** A pilot study was conducted to assess the suitability of the scale for use. A total of 30 individuals aged between 18 and 65 participated in the pilot study. The results indicated that the scale items were both readable and understandable to the participants. After the pilot application, the applicability of the scale form was reviewed from the perspective cognitive. Documentation. Once the scale form was finalized, it was reviewed by the research team to ensure cultural compatibility. Then the study was completed with 502 volunteers aged 18-65 who could read and understand Turkish adults. Provide relevant statistical evidence has been about the construct equivalence, method equivalence, and item equivalence for Turkish adult's populations. Test was used to evaluate the suitability of the data for factor analysis, and the Bartlett Test was applied to determine whether the variables were correlated with each other. This study was conducted as part of the Turkish validity and reliability study of Drake and Ogletree (2018) Weight and Health Scale. Confirmatory factor analysis is recommended for studies with a defined theoretical framework to assess construct validity (Alavi *et al.*, 2020; Fein *et al.*, 2022). However, because the CFA analysis results did not meet the fit indices, the study was re-evaluated with exploratory factor analysis. The factor structure of the scale was then identified using the scree plot. The scale's reliability was assessed through item-total correlation and Cronbach's alpha reliability coefficients.

**Administration:** The item and factor loadings previously determined within the scope of the study were not similar in the Turkish adult sample. In this context, the new factors obtained because of the study, and their item loadings were evaluated. Three factors were identified in the newly formed structure. The research team determined the names for these factors based on a literature review.

**The conceptual structure and naming of factors:** After establishing the three-factor structure in line with the scree plot, the factor names in the Weight and Health Scale were reconsidered. The items in the first, second,

and third factor structures are listed in Table 2. A review of the literature reveals a new paradigm in the philosophy of weight and health, suggesting that an individual's healthy weight cannot be solely determined by the numbers on a scale, by being underweight or obese as defined by the height/weight ratio, or by the percentage of body fat (Robison, 2005). According to this perspective, individuals' perceptions of health and weight diverge (Dey *et al.*, 2019), and their preferences for what their weight should be may fluctuate (Roberto *et al.*, 2016). Purpose-oriented goals, desires, and preferences in individuals' attitudes and behaviors reflect their process management (Brenton-Peters *et al.*, 2023).

**Factor 1:** Upon examining the items comprising the first factor, it becomes evident that there is a relationship between perceived weight and health (Dey *et al.*, 2019; Farrell *et al.*, 2021). Additionally, there is a management process aligned with individual goals and targets (Brenton-Peters *et al.*, 2023; Wharton *et al.*, 2020). Consequently, the research team, after a comprehensive literature review, designated the first factor as "Perceived Weight and Health Management."

**Factor 2:** The factor loadings of the second factor items range from 0.647 to 0.324. A literature review was conducted to identify what the items in the second factor structure were intended to measure. The review revealed that the perception levels of the weight and health relationship specified in the second factor structure vary among individuals (Dey *et al.*, 2019; Farrell *et al.*, 2021; Robison, 2005). Based on these findings, the research team designated the second factor as "Perceived Weight and Health Relationship."

**Factor 3:** The factor loadings of the third factor items range from 0.680 to 0.369. Another literature review was conducted to determine what the items in the third factor structure were intended to measure. The review indicated that perception levels of weight and health attitudes specified in the third factor structure also vary among individuals (Brenton-Peters *et al.*, 2023; Dey *et al.*, 2019; Farrell *et al.*, 2021; Fernández Batalla *et al.*, 2022; Powroznik, 2017; Wharton *et al.*, 2020; Zha *et al.*, 2022). Additionally, studies have shown that people develop attitudes and behaviors, such as

desire, discrimination, and stigmatization, because of these perceptions (Fruh *et al.*, 2021; Katz Kattari, 2023; McCormack and Pamarthi, 2019). Based on this information, the research team discussed and agreed that the most appropriate title for the third factor would be "Perceived Weight and Health Acceptance."

**Score scales and interpretation:** In the context of scale adaptation, a psychometric evaluation was conducted on the final version of the original scale to ensure its suitability for the Turkish cultural context. During this evaluation phase, exploratory factor analysis and confirmatory factor analysis were performed using the principal component method with varimax rotation to determine the structural validity of the scale. To assess the reliability of the scale, Cronbach's  $\alpha$  reliability coefficients and item-total correlations were considered.

**Documentation guidelines:** This research was reported according to International Test Commission (Bartram *et al.*, 2018).

**Data Analysis:** The IBM SPSS® Statistics for Windows version 25 software will be used for data analysis and descriptive research. Data will be presented as numbers and percentages. In the initial stages of the scale's validity and reliability analysis, its structural validity was examined. To assess the structural validity, the Kaiser-Meyer-Olkin (KMO) Test was used to evaluate the suitability of the data for factor analysis, and the Bartlett Test was applied to determine whether the variables were correlated with each other. The factor structure of the scale was then identified using the scree plot. The scale's reliability was assessed through item-total correlation and Cronbach's alpha reliability coefficients.

**Ethical Consideration:** Permission to conduct the Turkish validity and reliability study was obtained via e-mail from the original scale's developers, Drake and Ogletree (2018). Additionally, Ethics Committee approval was taken from Necmettin Erbakan University (Date: 06.04.2022, Number: 2022/11). The research was carried out under Declaration of Helsinki Good Clinical Practices. In addition, necessary permissions were taken from Provincial Health Directorate in the region. Individuals who volunteered to participate in

the study were asked to provide both verbal and written consent.

## Results

The sample for this study comprised a total of 502 individuals, of whom 348 (69.3%) were women and 154 (30.7%) were men. The participants' ages ranged from 18 to 64 years, with a mean age of  $33.58 \pm 9.37$  years. Among the participants, 303 (60.4%) were married, and 199 (39.6%) were single. Additionally, 251 (50%) were university students.

When classified according to BMI, 27 participants (5.4%) were underweight, 279 (55.6%) had a normal weight, and 142 (28.3%) were classified as overweight. A total of 54 participants (10.8%) were classified as obese. The mean body weight of the participants was  $68.38 \pm 14.37$  kg, the mean height was  $166.80 \pm 3.39$  cm, and the mean BMI was  $24.49 \pm 4.36$  kg/m<sup>2</sup>. The results are presented in Table 1.

To test the construct validity of the Weight and Health Attitudes Scale, an exploratory factor analysis was conducted using the principal components method with varimax rotation. The Bartlett's test of sphericity indicated that the data met the sphericity assumption ( $\chi^2(190) = 1397.513$ ,  $p < 0.001$ ). The analysis initially yielded a seven-factor structure with a KMO value of 0.71, explaining 56.48% of the total variance and with eigenvalues above 1. However, upon reviewing the results, it became apparent that no meaningful structure was formed. Consequently, the analysis was repeated by forcing a five-factor structure to align with the original design. The results of this second analysis also revealed that the five-factor structure significantly differed from the original. Finally, based on the scree plot, which suggested a three-factor structure, a three-factor model was tested. The results are presented in Figure 2.

Upon examining the results, a three-factor structure was identified, accounting for 40.26% of the total variance. Additionally, all items displayed factor loadings ranging from 0.33 to 0.79. Based on theoretical knowledge, the researchers agreed to name the three

factors as Perceived Weight and Health Management, Perceived Weight and Health Relationship, and Perceived Weight and Physical Acceptance. The internal consistency of the scale was evaluated using Cronbach's alpha coefficient, which yielded values of 0.775 for the Perceived Weight and Health Management sub-dimension, 0.787 for the Perceived Weight and Health Relationship sub-dimension, 0.749 for the Perceived Weight and Physical Acceptance sub-dimension, and 0.785 for the entire scale. The results are presented in Table 2.

The relationships between the total score and the subscales of the Weight and Health Attitudes Scale were examined using Pearson correlation analysis. The results indicated that all relationships between the sub-dimensions were positive and moderately significant ( $p < 0.001$ ). Additionally, the total score of the Weight and Health Attitudes Scale was found to be positively and significantly correlated with all subscales ( $p < 0.001$ ). The results are presented in Table 3. The scree plot further confirmed the presence of a three-factor structure in the dataset under examination. The total mean score obtained from the Health and Weight Attitude Scale by the participants in the study was  $-4.74 \pm 7.42$ . When the sub-dimensions were examined, Relationship Between Perceived Weight and Health was  $1.12 \pm 4.42$ , Relationship Between Perceived Weight and Health was  $-5.68 \pm 3.43$ , and Perceived Weight and Physical Acceptance was  $-0.17 \pm 3.16$ . The results are presented in Table 4.

In our study, exploratory factor analysis (EFA) was applied to examine the construct validity of the Turkish form of the original five-factor scale. However, because of the analysis, a statistically significant and theoretically consistent three-factor structure was obtained, which differed from the original structure. In this context, since the obtained structure did not overlap with the original scale, performing confirmatory factor analysis (CFA) would mean confirming a different model (Schmitt, 2011; Worthington and Whittaker, 2006).

**Table 1. Demographic variables of participants**

| Characteristics            | n              | %              |
|----------------------------|----------------|----------------|
| <b>Sex</b>                 |                |                |
| Females                    | 348            | 69.3           |
| Males                      | 154            | 30.7           |
| <b>Marital status</b>      |                |                |
| Married                    | 303            | 60.4           |
| Single                     | 199            | 39.6           |
| <b>Education level</b>     |                |                |
| Secondary education degree | 99             | 19.7           |
| High school degree         | 57             | 11.4           |
| University degree          | 251            | 50.0           |
| Master degree              | 95             | 18.9           |
| <b>BMI</b>                 |                |                |
| Thin                       | 27             | 5.4            |
| Normality                  | 279            | 55.6           |
| Overweight                 | 142            | 28.3           |
| Obese                      | 54             | 10.8           |
|                            | <b>Min-Max</b> | <b>Mean±Sd</b> |
| Age                        | 18-64          | 33.58-9.37     |
| Weight                     | 42-130         | 68.38-14.37    |
| Height                     | 145-193        | 166.80-3.39    |
| BMI                        | 15.94-45.54    | 24.49-4.36     |

BMI: Body mass index

**Table 2. Factor analysis and reliability analysis results of the weight and health attitudes scale**

| Items                                                                        | F1    | F2    | F3 |
|------------------------------------------------------------------------------|-------|-------|----|
| 8. Thin people are healthier than fat people.                                | 0.785 |       |    |
| 7. Being thin is good for your health.                                       | 0.740 |       |    |
| 18. Physically fit people are often thin.                                    | 0.648 |       |    |
| 14. Fat people sometimes have to ignore their hunger to manage their weight. | 0.523 |       |    |
| 22. Being thin is desirable.                                                 | 0.510 |       |    |
| 4. Health is the absence of disease.                                         | 0.389 |       |    |
| 12. Thin people must diet to maintain their weight.                          | 0.352 |       |    |
| 10. People need to control their weight for their health.                    |       | 0.647 |    |

|                                                                                      |        |        |        |
|--------------------------------------------------------------------------------------|--------|--------|--------|
| 16. People should exercise to control their weight.                                  | 0.604  |        |        |
| 2. A person's weight can determine their overall health                              | 0.530  |        |        |
| 1. A person's health is determined by the physical/biological condition of the body. | 0.528  |        |        |
| 9. Fat people do not need to lose weight to be healthy.                              | 0.463  |        |        |
| 19. People should not be encouraged to exercise to lose weight.                      | 0.443  |        |        |
| 13. Fat people should diet to lose weight.                                           | 0.409  |        |        |
| 3. The physical condition of the body is only one aspect of health.                  | 0.326  |        |        |
| 21. People of all sizes should be encouraged to accept their bodies.                 |        | 0.680  |        |
| 17. Fat people can be physically fit.                                                |        | 0.670  |        |
| 23. Society should be more accepting of fat people.                                  |        | 0.618  |        |
| 24. Fat people should be encouraged to accept their bodies.                          |        | 0.478  |        |
| 6. Healthy people sometimes have too much fat.                                       |        | 0.369  |        |
| <b>Total Variance Explained</b>                                                      | 25.026 | 34.252 | 40.260 |
| <b>Eigenvalue</b>                                                                    | 3.091  | 1.914  | 1.845  |
| <b>Cronbach Alpha</b>                                                                | 0.775  | 0.787  | 0.749  |

F1: Perceived Weight and Health Management F2: Relationship Between Perceived Weight and Health F3: Perceived Weight and Physical Acceptance

**Table 3. Correlation Analysis Between Total Score and Sub-Dimensions of the Weight and Health Attitudes Scale**

| Factors                                             | 1        | 2        | 3       |
|-----------------------------------------------------|----------|----------|---------|
| 1. Perceived Weight and Health Management           | 1        |          |         |
| 2. Relationship Between Perceived Weight and Health | 0.469*** | 1        |         |
| 3. Perceived Weight and Physical Acceptance         | 0.477*** | 0.515*** | 1       |
| 4. Weight and Health Attitudes                      | 0.799*** | 0.840*** | 0.791** |

\*\*\*  $p < .001$

**Table 4. Total and Sub-Dimensions of the Weight and Health Attitudes Scale**

|                                                  | Minimum | Maximum | Mean  | Std. Deviation |
|--------------------------------------------------|---------|---------|-------|----------------|
| Perceived Weight and Health Management           | -12.00  | 12.00   | 1.12  | 4.42           |
| Relationship Between Perceived Weight and Health | -16.00  | 7.00    | -5.68 | 3.43           |

|                                          |        |       |       |      |
|------------------------------------------|--------|-------|-------|------|
| Perceived Weight and Physical Acceptance | -9.00  | 8.00  | -.17  | 3.15 |
| Health and Weight Attitude Scale         | -35.00 | 16.00 | -4.74 | 7.42 |

## Discussion

A validity study is a criterion that determines the extent to which a measurement tool accurately evaluates the conceptual framework it is designed to assess. One of the most important characteristics of a valid measurement tool is construct validity (Finn and Anestis, 2017; Hinkin, 1995). Confirmatory factor analysis or exploratory factor analysis are recommended for assessing construct validity. However, confirmatory factor analysis is recommended instead of exploratory factor analysis for studies that have previously assessed validity, and for studies where the factors identified and the factors on which variables load conceptually are specified (Fein *et al.*, 2022). Construct validity is a crucial method for evaluating the validity of a psychometric measurement tool. Although factor analysis is the preferred method for establishing construct validity (Finn and Anestis, 2017), in our study, exploratory factor analysis was performed using the principal components method with varimax rotation. The findings indicated a seven-factor structure with eigenvalues greater than one, which appeared to meet the sphericity assumption based on the Bartlett's test results ( $\chi^2(190) = 1397.513$ ,  $p < 0.001$ ), with a KMO value of 0.71, explaining 56.48% of the total variance. However, it was observed that the conceptual structure had not been clearly formed. Consequently, further analysis was conducted on the five-factor structure of the original scale. It was discovered that the items grouped within the factors differed from those in the original scale developed by Drake and Ogletree (2018). The scree plot indicated a three-factor structure in our study. Although there are studies in the literature that evaluate the scree plot (Ezzedine *et al.*, 2020), we focused our analysis on the three-factor structure for the Weight and Health Scale. This analysis resulted in a three-factor structure, explaining 40,26% of the total variance, with item factor loadings ranging between 0.33 and 0.79. For single-factor structures, the explained variance is required

to be at least 30% (Buyukozturk, 2024). When the literature is examined, there are studies showing that the variance explained in studies with two or more factors is at least 40% (Arkan *et al.*, 2019; Arkan, Bostanlı and Bektas, 2025). It is also stated that a variance between 40-60% is acceptable (DeVellis and Thorpe, 2021). In the study, CFA based on three factors was performed, but the model fit was found to be weak. The main reason for this is that the new structure obtained differs from the original measurement model. As stated in the literature, performing CFA directly in line with the structural differences revealed by EFA should be evaluated not only for model validation but also with theoretical justification (Brown, 2015). In this context, we believe that it would be more meaningful and consistent to evaluate the structure obtained by EFA in terms of properly conducting the Turkish validity study, which is the main purpose of the study. The factor structures were determined by considering theoretical and conceptual frameworks (Denche-Zamorano *et al.*, 2023; Hsu and Chiang, 2020) and through the consensus of the researchers conducting the study. The scale assesses perceived weight and health management, the relationship between the two, and the construct is designated as Perceived Weight and Physical Acceptance

The reliability of a psychometric measurement tool is of paramount importance, as it ensures the accuracy and consistency of the results obtained (Revelle and Condon, 2018). Following the completion of the analyses, the total Cronbach's alpha internal consistency coefficient of the scale was determined to be .785. Additionally, the Cronbach's alpha internal consistency coefficients for the scale's factors—Perceived Weight and Health Management, Perceived Weight and Health Relationship, and Perceived Weight and Physical Acceptance—were found to be .775, .787, and .749, respectively. In psychometric measurement tools, a value range of  $0,60 \leq \alpha \leq 0,80$  indicates that the measurement tool is

statistically reliable (Revelle and Condon, 2018).

**Conclusion and Recommendations:** Based on the research findings, it was determined that the Weight and Health Attitude Scale is a valid and reliable measurement tool. This scale can be utilized in studies aimed at assessing individuals' weight and health attitudes, perceived weight and health management, perceived weight and health relationship, and perceived weight and physical acceptance. The Health and Weight Attitudes Scale, which has been determined to be valid and reliable, has been identified with different factors than those in the Drake and Ogletree (2018) study. It is believed that the results obtained in this study will guide all researchers and create a new approach to assessing individuals' health and weight attitudes.

**Limitations:** A significant limitation of this study was that the scale developed by Drake and Ogletree (2018) was evaluated for Turkish validity using CFA, and it was concluded that it was not suitable. Therefore, the study was re-evaluated using EFA.

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