International Journal of Nutrition Sciences

Journal Home Page: ijns.sums.ac.ir

ORIGINAL ARTICLE

The Relationship between Body Mass Index and Eating Disorder Risk and Intuitive Eating among Young Adults

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ARTICLE INFO

Keywords:
Intuitive eating
Eating disorder
Body mass index
Young adults
Obesity

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Received: June 8, 2021
Revised: October 21, 2021
Accepted: October 30, 2021

ABSTRACT

Background: Obesity is a serious health problem that threatens public health. There are limited researches exploring the relationship between obesity and eating disorder risk and intuitive eating. The purpose of this study was to determine the rate of eating disorder risk and obesity, and identify the relationship between body mass index (BMI) and eating disorder risk and intuitive eating among young adults.

Methods: This cross-sectional study enrolled 1216 young adults. The data were obtained through a questionnaire consisted of three sections of socio-demographic information in the first part, Intuitive Eating Scale-2 (IES-2) in second part and Eating Attitudes Test-26 (EAT-26) in third part. Weight, height, and BMI of participants were also measured by researchers.

Results: The overall overweight/obesity rate of the participants was 16% (male=25.9%; female=10.9%). The rate of eating disorders risk was 24.3% in general (male=21.5%; female=25.4%). Overweight/obese had higher eating disorders risk than normal and underweight (26.7%, 23.8%, 21.6%, respectively). IES-2 score of underweight was significantly higher than overweight/obese (3.33±0.35, 3.20±0.37, respectively).

Conclusion: This is the first study to examine the relationship between BMI and EAT-26 subscale showing that BMI was positively correlated with EAT-26 and negatively was correlated with IES-2 score. Therefore, BMI may be affected by eating behaviors and intuitive eating. Also, intuitive eating can be a new method of eating, and weight control and management.

Please cite this article as: Yılmaz HÖ, Zemzemoglu TEA. The Relationship between Body Mass Index and Eating Disorder Risk and Intuitive Eating among Young Adults. Int J Nutr Sci. 2021;6(4):180-188. doi: 10.30476/IJNS.2021.91438.1138.

Introduction

Obesity has become an important health issue that has become a major concern in many countries worldwide. Overweight and obesity are defined by World Health Organization (WHO) as an abnormal or excessive fat accumulation that presents a risk to health (1). Situations such as developing technology, women being more involved in business life, intense work tempo have caused consumption of foods that are insufficient in terms of nutrients, low in fiber content, high saturated fat and added sugar (2). The number of obese individuals is increasing with the changes in the diet and decreasing level of physical activity in last decades. According to WHO; obesity is an important health problem that can affect all age groups, has a high prevalence, and impacts individuals' social and psychological activities (1, 3)exercise and other behavior change.

This approach reliably induces short term weight loss, but the majority of individuals are unable to maintain weight loss over the long term and do not achieve the putative benefits of improved morbidity and mortality. Concern has arisen that this weight focus is not only ineffective at producing thinner, healthier bodies, but may also have unintended consequences, contributing to food and body preoccupation, repeated cycles of weight loss and regain, distraction from other personal health goals and wider health determinants, reduced self-esteem, eating disorders, other health decrement, and weight stigmatization and discrimination. This concern has drawn increased attention to the ethical implications of recommending treatment that may be ineffective or damaging. A growing trans-disciplinary movement called Health at Every Size (HAES. This situation causes many chronic diseases such as diabetes, cardiovascular diseases, and cancer that can be associated with nutritional status worldwide (2).

An energy-restricted diet along with physical activity are the best choices for weight loss and are generally accepted to decrease the risk and severity of obesity-related comorbidity (4, 5). However, in this procedure, the benefits of weight loss are often short- to medium-term (6). In energy-restricted diets, low or no intake of certain nutrients or food groups is applied for weight loss purposes. Individuals are encouraged to rely on control of eating time, food amount, and type of food consumed, instead of relying on self-hunger, fullness, and appetite signals (7). This situation affects the sustainability of diets long term. But even if this type of diet is stopped, negative behaviors such as food anxiety, metabolic disorder, and a tendency to binge eating can be observed (2).

Failures of weight loss and control in long-term with traditional methods have led some experts to discover the new approach as defined "adaptive eating" and "intuitive eating", which they also call "normal eating" (8). Intuitive eating is defined as "The accordance of mind, body and food integrated into the dynamic process". Basically, it is a method of eating that takes into account hunger and satiety signals to control food intake (9). Intuitive eating consists of 10 principles. These are (a) Reject the Diet Mentality, (b) Honor Your Hunger, (c) Make Peace with Food, (d) Challenge the Food Police, (e) Discover the Satisfaction Factor, (f) Feel Your Fullness, (g) Cope with Your Emotions with Kindness, (h) Respect Your Body, (i) Movement-Feel the Difference, and (j) Honor Your Health-Gentle Nutrition (10).

In cross-sectional studies about intuitive eating, a negative relationship has been reported between weight and intuitive eating (11-14). It is reported that body image and self-esteem increase emotional eating tendencies and body mass index (BMI) decreases in individuals who practice the intuitive eating style (15). In studies conducted on female and male samples, it was reported that the increase in IES score can cause a decrease in BMI (8, 16). Eating disorder is associated with eating behaviors and impaired body image. It is a health problem that usually appears in adolescence and females. If it is untreated, it may become chronic and cause psychological, medical and social problems (17).

Eating disorders are effected risk factor such as impaired eating attitude, body dissatisfaction, negative beliefs about self, and internalization of ultra-thin ideal (17, 18). It is remarkable that many psychological problems, especially risky eating behaviors are common among university students who are young adults (17, 19). In Turkey, and worldwide, eating disorders and obesity are increasing in young adults. However, limited studies have evaluated the relationship between BMI and intuitive eating and eating attitudes. Therefore, this study aimed to determine the ratio of eating disorder risk and obesity, and identify the relationship between BMI and intuitive eating and eating attitudes among young adults.

Materials and Methods

Participants were selected with simple random sampling method among all students studying at the Faculty of Health Sciences of Gumuşhane University during January-March 2019. A total of 2200 students received education in the faculty. Those who filled the questionnaire incorrect or incomplete, were not volunteers to participate and could not be reached were not included. So this study was completed with a total of 1216 participants (33.6% male and 66.4% female).

The Intuitive Eating Scale-2 determines when, what, and how much eating and measures the tendency to physical hunger and satiety. This scale has 23-items and 5-point Likert-type tool that assesses four main components of intuitive eating. (i) Unconditional permission to eat (UPE): 6 items; e.g., "If I'm craving a certain food, I allow myself to have it". (ii) Eating for physical reasons (EPR): 8 items; e.g., "I mostly eat foods that make my body perform efficiently". (iii) Reliance on hunger and satiety cues (RHSC): 6 items; e.g., "I rely on my hunger signals to tell me when to eat". (iv) Body-food choice congruence (B-FCC): 3 items; e.g., "I mostly eat foods that give my body energy and stamina" (14).

Responses ranged from 1 (strongly disagree) to 5 (strongly agree). To score the Intuitive Eating Scale–2 (IES-2), negative items were reversely coded and then added together to a composite score, which was then divided by the number of items to produce a mean score. Turkish version validity and reliability were provided by Baş *et al.* as Cronbach's alpha was 0.81 (20), while in our study was found 0.79. The Eating Attitudes Test is a widely used self-report measure for eating disorders. It was developed by Garner and Garfinkel to measure symptoms of anorexia nervosa (21). It contains 26 items with answers on a Likert-type scale (0=never, hardly ever or occasionally; 1=sometimes; 2=often; 3=always). Total scores on the Eating Attitudes Test-26 (EAT-26) are derived as a sum of the composite items, ranging from 0 to 53, with the score of 20 on the EAT-26 that was used as a cut-off. Scores ≥20 indicate risk behavior for triggering eating disorders (22).

The EAT-26 consisted of three-subscale to evaluate the impact of environmental and social factors on eating. (i) Diet, related with degree of avoidance of fattening foods and preoccupation with being thinner. (ii) Bulimia and preoccupation with food, referring to episodes of compulsive eating followed by purgative behavior for weight loss/control. (iii) Oral control, the degree of self-control around food and the perception of pressure from others to gain weight. The Turkish version reliability of EAT-26 was also determined by Bas *et al.* as Cronbach's alfa was 0.70 (23). In our study, it was found 0.76.

Weight (kg) was measured with a calibrated and 0.5 kg-sensitive scale device (Fakir, GER). Height was measured (cm) with feet close together and the head in the Frankfort plane position using a 0.1 cm-sensitive portable stadiometer (Radwag, PL). Measurements were made early morning, while the participants were fasting and wearing light garments without shoes. All anthropometric measurements were obtained by researchers in an empty room. Weight (kg) was divided to the square of the height (m) to calculate the BMI value (BMI=weight/height^2). The BMI values of the participants were grouped into three categories according to WHO classification including underweight (BMI<18.5 kg/m^2), normal or healthy weight (18.5-24.9 kg/m^2), and overweight/obese (BMI ≥25.0 kg/m^2) (24).

The researchers conducted by face-to-face interviews using a questionnaire were consisted of questions on demographic characteristics, health status, IES-2 and EAT-26. Before beginning the study, a pilot study was undertaken with 30 participants. At the end of the pilot study, some corrections were made to the questions of the questionnaire according to the suggestions of the participants and the final version was completed. At the beginning at the study, written permission was obtained from the Dean of the Faculty of Health Sciences, Gumuşhane University. With the permission, the application was made to the Scientific Research and Publication Ethics Committee of Gumuşhane University and ethical approval was obtained on 24/12/2018 with the number of 95674917-108.99-E.39884. Before the research, participants were informed about the study by the researcher. Written approval was obtained from the participants and participants were included based on volunteering in the study.

Normality of data for continuous variables was assessed using histogram graphics, detrended plots, the Kolmogorov-Smirnov test, and skewness or kurtosis. Descriptive data were given as number (n), percent (%), mean ($\bar{X}$) and standard deviation (SD). Independent sample-t test was used for mean comparisons of binary groups. Chi-Square test was used for comparisons of categorical variables. One-way ANOVA test (Post-hoc Benferroni Correction Test, $p<0.05/3=0.0167$) was used to determine mean data of more than two groups. The correlation of continuous variables (BMI, IES-2 and EAT-26 scale scores) was evaluated using Pearson Correlation test. The significance level was accepted as $p<0.05$ in all statistics. All statistical data were analyzed using The Statistical Package for Social Sciences (SPSS, version 24.0, SPSS Inc., Chicago, IL, USA).

Results

The study was completed with a total of 1216 participants (33.6% male and 66.4% female), while 24.2% of the students received education in health management and 21.8% in nursing department. Among them, 29.3% had educational level in the 1st grade and 27.5% in the 2nd grade. Also, 68.9% had a household financial monthly income <TL 3,000, whereas 64.6% lived in a dormitory (Table 1).

Among participants, 10.0% were underweight, 74.0% were normal, whereas 16.0% were overweight/obese. Overweight/obese ratios in females and males were 10.9% and 25.9%, respectively. Totally, 78.5% of the males did not have any eating disorder risk, whereas 25.4% of the females reported an eating disorder risk. The overall eating disorder risk was 24.1%. Mean BMI was 23.42±3.53 kg/m^2 for males and 21.59±3.38 kg/m^2 for females, with an overall of 22.20±3.54 kg/m^2. The overall EAT-26 score of the participants was 14.98±6.08 ($p<0.001$). Dieting score, a subscale of EAT-26 was 5.55±3.51 in males and 6.03±4.09 in females ($p<0.05$). The overall IES-2 score of the participants was 3.26±0.35. UPE and B-FCC scores, which are subscales of IES-2 were

Table 1: Socio-demographic characteristics of participants.

Variable	n	%
Gender		
Male	409	33.6
Female	807	66.4
Department		
Nutrition and dietetics	182	14.9
Nursing	267	21.8
Social work	141	11.6
Occupational health and safety	223	18.3
Health management	294	24.2
Emergency and disaster management	109	9.0
Grade		
First	356	29.3
Second	335	27.5
Third	312	25.7
Fourth	213	17.5
Family income (Monthly)		
<TL 3000 (Low)	838	68.9
TL 3001–5000 (Normal)	292	24.0
>TL 5000 TL (High)	86	7.1
Accommodation		
Dormitory	785	64.6
Apart/Student house	388	31.9
Family	43	3.5
Smoking		
Yes	271	22.3
No	945	77.7
Alcohol use		
Yes	159	13.1
No	1057	86.9
Chronic diseases*		
Yes	191	15.7
No	1025	84.3

*Diagnosis of chronic disease by doctor (chronic renal failure, cancer, asthma, diabetes etc.).

higher than that in females and EPR and RHSC scores were lower than that in males. The difference between UPE, EPR and B-FCC scores by gender was statistically significant ($p<0.01$) (Table 2).

When eating disorder risk was compared according to the BMI groups of the participants, eating disorder risk was 21.6% for underweight, 23.8% for the normal weight and 26.7% for the overweight/obese groups. The overall EAT-26 score was significantly higher in overweight/obese than in underweight and normal ($p<0.01$). Dieting score, a subscale of EAT-26, was determined to be the highest in the overweight/obese group, whereas bulimia and oral control scores were highest in the underweight group. Dieting and oral control scores were statistically different among all groups ($p<0.001$), whereas bulimia score was statistically different among the underweight and overweight/obese group ($p<0.05$). The overall IES-2 score was highest in the underweight group (3.33±0.35). Though the overall IES-2 score did not differ significantly among the underweight and normal groups, it differed significantly in the overweight/obese group. UPE, EPR, RHSC and B-FCC scores, which are subscales of EAT-26, were higher in underweight group than in other groups. While UPE score was different among all groups ($p<0.001$), B-FCC score showed a statistically significant difference between the underweight and overweight/obese group ($p<0.01$) (Table 3).

The participants' BMI values and the correlations of IES-2 and EAT-26 overall scores and sub-scale scores were presented in Table 4. In respect of individual' BMI values, there was a negative statistically significant correlation with IES-2 score and a positive correlation with the EAT-26 score (IES-2: r=-0.112 $p<0.001$, EAT-26: r=0.134 $p<0.001$); while negative correlation between UPE and B-FCC which are sub-scales of the IES-2 scale ($p<0.001$), and BMI was statistically significant. There was a

Table 2: BMI, EAT-26 and IES-2 scores of participants by gender.

	Male		Female		Total		χ^2	*p**
	n	%	n	%	n	%		
BMI classification								
Underweight	20	4.9	102	12.6	122	10.0		
Normal	283	69.2	617	76.5	900	74.0	56.535	0.000
Overweight/Obese	106	25.9	88	10.9	194	16.0		
Eating disorder risk								
Yes	88	21.5	205	25.4	293	24.1	1.094	0.296
No	321	78.5	602	74.6	923	75.9		
	$\bar{X}$±SS		$\bar{X}$±SS		$\bar{X}$±SS		t	*p**
Mean BMI	23.42±3.53		21.59±3.38		22.20±3.54		-8.776	0.000
EAT-26								
General	14.73±6.06		15.11±6.09		14.98±6.08		1.024	0.306
Diet	5.55±3.51		6.03±4.09		5.87±3.91		2.144	0.032
Bulimia	5.14±2.58		4.98±2.35		5.03±2.43		-1.110	0.267
Oral control	4.04±3.23		4.10±3.44		4.08±3.37		0.281	0.779
IES-2								
General	3.27±0.35		3.25±0.35		3.26±0.35		-0.916	0.360
UPE	3.39±0.51		3.27±0.44		3.31±0.47		-4.086	0.000
EPR	2.88±0.49		2.96±0.55		2.93±0.53		2.782	0.006
RHSC	3.39±0.60		3.43±0.57		3.41±0.58		1.192	0.234
B-FCC	3.88±0.78		3.65±0.80		3.73±0.80		-4.738	0.000

Data were presented as mean±SD for continues variables, and number and percentages for categorical variables. *Independent sample t test and Chi Square were used for continuous and categorical variables, respectively. BMI: Body Mass Index, EAT: Eating Attitudes Test, IES: Intuitive Eating Scale, UPE: Unconditional permission to eat, EPR: Eating for physical reasons, RHSC: Reliance on hunger and satiety cues, B-FCC: Body-food choice congruence.

Table 3: EAT-26 and IES-2 scores according to participants' BMI classification.

	Underweight[1]		Normal[2]		Overweight/Obese[3]		χ^2	*p*
	n	%	n	%	n	%		
Eating disorders risk								
Yes	27	21.6	214	23.8	52	26.7	4.070	0.131
No	95	78.4	686	76.2	142	73.3		
EAT-26	$\bar{X}$±SS		$\bar{X}$±SS		$\bar{X}$±SS		F	*p**
General	15.17±5.91		15.31±5.91		17.01±6.89		4.049	$0.026^{1-3.2-3}$
Diet	4.03±2.95		5.75±3.75		8.46±4.61		28.277	$0.000^{1.2.3}$
Bulimia	5.10±2.58		5.07±2.41		4.79±2.42		3.254	0.028^{1-3}
Oral control	6.03±3.60		4.54±3.32		3.75±2.61		45.395	$0.000^{1.2.3}$
IES-2								
General	3.33±0.35		3.27±0.35		3.20±0.37		5.210	$0.006^{1.3}$
UPE	3.47±0.44		3.30±0.46		3.24±0.47		10.051	$0.000^{1.2.3}$
EPR	2.97±0.50		2.94±0.53		2.91±0.56		0.499	0.607
RHSC	3.43±0.59		3.40±0.62		3.36±0.53		0.935	0.303
B-FCC	3.84±077		3.74±0.80		3.57±0.82		5.051	$0.007^{1.3}$

*One-way ANOVA, Post-hoc Benferroni correction (p<0.05/3=0.0167), p value between groups. Data were presented as mean±SD for continues variables, and number and percentages for categorical variables. *Independent sample t test and Chi Square were used for continuous and categorical variables, respectively. BMI: Body Mass Index, EAT: Eating Attitudes Test, IES: Intuitive Eating Scale, UPE: Unconditional permission to eat, EPR: Eating for physical reasons, RHSC: Reliance on hunger and satiety cues, B-FCC: Body-food choice congruence.

negative correlation between EPR and RHSC and BMI, which was not statistically significant (p>0.05). Dieting score, which is a subscale of EAT-26, had a positive correlation with BMI (r=0.152 p<0.001), whereas bulimia (r=-0.034, p>0.05) and oral control (r=-0.271, p<0.001) scores had a negative correlation with BMI (Table 4).

Discussion

In this study, obesity, eating attitude and intuitive

Table 4: Correlations BMI with IES-2 and EAT-26.

	r	*p**
IES-2	-0.112	<0.001
UPE	-0.121	<0.001
EPR	-0.050	>0.05
RHSC	-0.019	>0.05
B-FCC	-0.123	<0.001
EAT-26	0.134	<0.001
Diet	0.152	<0.001
Bulimia	-0.034	>0.05
Oral Control	-0.271	<0.001

*Pearson Correlation Test. BMI: Body Mass Index, EAT: Eating Attitudes Test, IES: Intuitive Eating Scale, UPE: Unconditional permission to eat, EPR: Eating for physical reasons, RHSC: Reliance on hunger and satiety cues, B-FCC: Body-food choice congruence

eating of university students and their correlations with each other were examined. The prevalence of obesity was relatively higher among young adults. In studies on the subject, Khabaz *et al.* (25) found that 34% of the students who participated in their study were obese and 34% were overweight. In another study conducted in China, in which 1220 university students were included, the ratio of overweight/obese was determined to be as 11.6% (26). Özkan *et al.* (27) found that the obesity ratio in university students was 11.4%. In our study, the ratio of overweight/obese individuals was 16.0%, overall. It is considered that the difference between these studies in terms of obesity frequency may be affected by several variables such as locality (country and city), food culture, student profile and a combination, thereof.

Eating disorder is a psychological problem that can be seen in young adults. The incidence of this problem among students was found differently in conducted studies. In a study on 3148 university students, Pengpid and Peltzer (28) determined that 11.5% of students had an eating disorder risk. In a similar study, Sanlier *et al.* (29) reported that eating disorder risk was 19.3% in 1359 university students. In another study conducted with 454 university students, eating disorder risk among the students was 4% (30). In our study, it was found that 24.3% of the participants had a higher eating disorder risk compared to similar studies. It is considered that this may be attributable to the effect of psychological factors associated with eating disorders, such as depression and low self-esteem.

Being a current and new concept, intuitive eating has been assessed in various samples including university students. In a study carried out to determine intuitive eating status among university students, overall IES-2 score of the students was found to be 3.40 (31). In a similar study undertaken among students, Baş *et al.* (20) found that overall IES-2 score was 3.08. Özkan and Bilici (27) reported that the mean score of the IES-2 scale was 3.3±0.3 indicating statistically significant difference by genders (Male: 3.5±0.3, Female: 3.3±0.3). In our study, this score was found to be 3.26±0.35 suggesting no significant difference by gender.

The eating disorder risk can be seen not only in underweight individuals but also in all BMI groups. In a study including 750 individuals, Karadağ *et al.* (32) demonstrated that the percent of eating disorder was 29.6% in overweight individuals. In a similar study, where eating disorders of 525 students were evaluated, it was determined that 23.7% of overweight/obese individuals, 12.3% of normal weight individuals and 4.4% of underweight individuals had an eating disorder risk (33). In another study, eating disorder risk was 10.4% among all students, and this ratio was significantly higher in the overweight/obese group (21.7%) in comparison to other groups (underweight group: 6.1%, normal group: 6.4%) (30). In another study evaluating university students eating attitudes and their sub-scales, the average EAT-26 score of obese individuals was higher than other groups (34). In this study, it was also found that dieting and bulimia scores, which were subscales of EAT-26, were higher and oral control was lower in obese individuals when compared to other individuals. The findings of our study are similar to other studies on the subject. In our study, both eating disorder risk and average overall EAT-26 scores were higher in the overweight/obese group when compared to underweight and normal groups. This result may be attributed to higher dieting score of overweight/obese group although oral control score was lower than other groups.

In the literature, there are limited studies examining the mean values of IES-2 and its sub-scales according to BMI groups. Kuseyri and Kızıltan (35) showed that overweight/obese individuals had a

significantly lower overall IES-2 score compared to other groups. They also illustrated that UPE, EPR and RHSC scores, which are subscales of IES-2, were lower in the obese group than in other groups, whereas B-FCC scores were similar ($p<0.05$). According to the results of our study, the overweight/obese individuals had lower overall IES-2 ($p<0.01$), UPE ($p<0.001$), EPR ($p>0.05$), RHSC ($p>0.05$) and B-FCC ($p<0.01$) scores compared to other groups. According to these findings, it is concluded that overweight/obese individuals restrict themselves more when eating is compared to other groups, and they act emotionally rather than physically, and they rely less on hunger-satiety signals and pay less care to the relationship between body and food intake.

In the literature, the relationship between BMI with intuitive eating and eating attitudes is unclear. In literature, different results were achieved in studies examining intuitive eating, eating attitude with BMI correlation. In a study involving 530 individuals, Ruzanska and Warschburger (36) determined a negative correlation between the BMI and IES-2 (r=-0.15, $p<0.001$). In a similar study, it was found that BMI and IES-2 scores had a negative correlation (r=-0.089, $p>0.05$) (37). In another study, correlation was found between BMI and IES overall score (r=-0.25), and UPE (r=-0.29), EPR (r=-0.05) and RHSC (r=-0.14) (38). In a similar study, Bas *et al.* found a negative correlation between the BMI and IES-2 overall score (r=-0.277, $p<0.01$), UPE (r=-0.103, $p<0.05$), EPR (r=-0.274, $p<0.01$), RHSC (r=-0.089, $p>0.05$) and B-FCC (r=-0.092, $p>0.05$) (20). In our study, IES-2 overall score and subscales were found to have a negative correlation with BMI. According to the findings of our study, intuitive eating had a negative and poor correlation with BMI, which was statistically significant.

Evaluation of other studies investigating the correlation between the EAT-26 overall score and BMI revealed conflicting results. In a study conducted with university students, a positive correlation was found between EAT-26 score and BMI (r=0.172, $p<0.001$) (39). In another study, contrary to this result, a negative correlation was found (r=-0.136) (29). In a similar study involving young adults, a positive correlation was found between BMI and EAT-26 score (r=0.445, $p<0.001$) (40). In the study, in which the correlation between EAT-26 and BMI in adult male and female was assessed, a negative correlation was found in both groups, however, this correlation was not statistically significant (Males: r=-0.046, $p>0.05$; Females: r=-0.053 $p>0.05$) (27). In our study, a positive and statistically significant correlation was found between EAT-26 overall score and BMI (r=0.134, $p<0.001$). This finding is similar to some of the studies on the subject. This is due to the fact that eating disorder can be seen not only in overweight/obese individuals, but also in individuals with low and normal BMI values. Therefore, it should be considered to incorporate not only EAT-26 score, but also EAT-26 subscales into these studies. It is argued that the relationship between EAT-26 and BMI can therefore be explained and interpreted more accurately. When the relevant literature is reviewed, our study is considered to be the first study to examine the correlation between EAT-26 subscales and BMI. In our study, a positive correlation was found between BMI and EAT-26 sub-scale dieting score, and a negative correlation between BMI and bulimia and oral control score.

Conclusion

In summary, the rate of underweight and overweight/obesity was shown to be significantly higher among the young adults of our study. A positive correlation was found between EAT-26 score and BMI. Also, a negative correlation was noticed between IES-2 score and BMI. It is thought that intuitive eating, which is defined as a new method in weight control, can be used particularly in overweight/obese individuals. The basic principles of intuitive eating should be clearly communicated to individuals, followed up regularly and any possible problems should be eliminated. Thus, it will be possible to improve the chance of success on weight management. In the light of the findings achieved, this study may suggest a hypothesis for further studies to evaluate the relationship between intuitive eating and BMI.

Acknowledgment

We gratefully acknowledge Mervenur Betül Akıncı, Seda Horasan, Şükran Fındık and Kübra Güder for assistance with data collection.

Conflict of Interest

None declared.

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