

T.C.
YEDİTEPE UNIVERSITY
INSTITUTE OF HEALTH SCIENCES
DEPARTMENT OF NUTRITION AND DIETETICS

**INVESTIGATION OF THE RELATIONSHIP
BETWEEN INTUITIVE EATING AND EATING
ATTITUDE IN PEOPLE WHO HAVE REGULAR
NUTRITION COUNSELING AND WHO HAVE NOT**

MASTER'S THESIS

TANSU NUR ÇALIM

İstanbul–2022

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THESIS APPROVAL FORM

Institute : Yeditepe University Institute of Health Sciences
Programme : Nutrition and Dietetics
Title of the Thesis : Investigation of The Relationship Between Intuitive Eating and Eating Attitude In People Who Have Regular Nutrition Counseling and Who Have Not
Owner of the Thesis : Tansu Nur Çalım
Examination Date : 06.04.2022

This study have approved as a Master Thesis in regard to content and quality by the Jury.

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APPROVAL

This thesis has been deemed by the jury in accordance with the relevant articles of Yeditepe University Graduate Education and Examinations Regulation and has been approved by Administrative Board of Institute with decision dated and numbered

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DECLARATION

I hereby declare that this thesis is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which has been accepted for the award of any other degree except where due acknowledgment has been made in the text.

TANSU NUR ÇALIM



ACKNOWLEDGEMENTS

I would like to express my thanks to;

My dear thesis advisor Assist. Prof. Dr. Hülya DEMİR who always supported and guided me with her knowledge and experience and her loving approach during the thesis period;

My dear mother Songül ÇALIM, my dear father Şükrü ÇALIM and my dear brother Mehmet ÇALIM who did not leave me alone during my graduate education, as well as throughout my life, who never left their love and who were my greatest luck;

My dear close friend, cognitive neuropsychologist Beyza SEVİM, who motivated me when I was in trouble and supported me a lot thanks to her experience and professional identity;

And all my other loved ones who always hold my hand and support me with their love during this process.

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LIST OF SYMBOLS AND ABBREVIATIONS

n: Number of Samples

p: Difference Value

WHO: World Health Organization

BMI: Body Mass Index

EAT: The Eating Attitude Scale

IES: Intuitive Eating Scale

EPR: The Eating for Physical Rather Than Emotional Reasons

UPE: The Unconditional Permission to Eat

RHSC: Reliance on Hunger and Satiety Cues

BFCC: The Body-Food Choice Congruence

ABSTRACT

Çalm, T. (2022). “Investigation of the relationship between intuitive eating and eating attitude in people who have regular nutrition counseling and who have not”. Yeditepe University Institute of Health Sciences, Department of Nutrition and Dietetics. Master’s Thesis. İstanbul.

This study was carried out in order to evaluate the relationship between intuitive eating and eating attitudes and to compare them with groups that do not/diet. The study was conducted with 100 adult volunteers who were randomly selected. Forms created for this study in order to collect data; Intuitive Eating Scale, Eating Attitude Scale and a questionnaire including the socio-demographic characteristics of the participants were used.

In the study, it was determined that there was a strong relationship between emotional eating and all subscales of the Intuitive Eating Scale ($p<0.05$). In addition, the body mass index, weight and height data obtained from the participants; It was concluded that the intuitive eating scale had a significantly negative relationship with all subscales. However, all subscales of the intuitive eating scale; It was also found that there is a relationship between education level, dieting status and having a medical disorder. Considering the results of the study, it is understood that having an intuitive eating and eating attitude awareness is effective in creating a healthy lifestyle. For this reason, it is necessary to develop new strategies by providing more training in this area.

Key words: Eating attitude, Intuitive Eating, Nutrition

ÖZET

Çalım, T. (2022). “Düzenli beslenme danışmanlığı alan ve almayan kişilerde sezgisel yeme ve yeme tutumu ilişkilerinin incelenmesi”. Yeditepe Üniversitesi Sağlık Bilimleri Enstitüsü, Beslenme ve Diyetetik ABD. Master Tezi. İstanbul. Bu çalışma sezgisel yeme ve yeme tutumu ilişkisinin değerlendirilmesi ve diyet yapmayan/yapan gruplarla birlikte araştırılması amacıyla İstanbul-Bayrampaşa’da ikamet eden 25-55 yaş arasında olan ve Bayrampaşa Belediyesi Sağlık İşleri Müdürlüğü’ne beslenme danışmanlığı için başvuran 100 yetişkin gönüllü ve herhangi bir diyet program uygulamayan rastgele seçilecek 100 yetişkin gönüllüyle çalışılmıştır. Veri toplamak amacıyla bu çalışma için oluşturulan formlar; Sezgisel Yeme Ölçeği, Yeme Tutum Ölçeği ve katılımcıların sosyo-demografik özelliklerinin içerdiği anket formu kullanılmıştır.

Araştırmada duygusal yeme ile Sezgisel Yeme Ölçeğinin tüm alt ölçekleri arasında güçlü bir ilişki olduğu saptanmıştır ($p<0.05$). Ayrıca, katılımcılardan alınan beden kitle indeksi, ağırlık ve boy verilerinin; sezgisel yeme ölçeğinin tüm alt ölçekleri ile anlamlı derecede negatif ilişkiye sahip olduğu sonucuna varılmıştır. Bununla birlikte, sezgisel yeme ölçeğinin tüm alt ölçeklerinin; eğitim düzeyi, diyet yapma durumu ve tıbbi rahatsızlık olması arasında da ilişki olduğu saptanmıştır. Çalışmanın sonuçlarına bakıldığında sezgisel yeme ve yeme tutumu farkındalığına sahip olmanın sağlıklı yaşam tarzı oluşturmada etkili olduğu anlaşılmaktadır. Bu sebeple bu alanda daha çok eğitim verilerek yeni stratejiler geliştirilmesi gereklidir.

Anahtar Kelimeler: Yeme tutumu, Sezgisel Yeme, Beslenme

1. INTRODUCTION

Nourishment is the intake of food that is considered to be related to the dietary needs of the body. Eutrophy- an adequate, well-balanced diet combined with regular physical activity - is the cornerstone of good health. Hypoalimantation may result in decreasing immunity, increasing susceptibility to diseases, decreasing physical and mental development and productivity (1). Intuitive eating is expressed as "the dynamic integration of mind, body and nourishments". Furthermore, it can be defined as a concept that regulates food intake and is shaped according to the perception of hunger and satiety. Thus, it creates a strong relationship between the perception of hunger and satiety and the body, based on instinctual awareness (2). It is emphasized that the development of healthy eating attitude and the increase in the intuitive eating skill and thus its protective role in weight control and possible eating disorders (3). Crerand et al. (4) found that weight loss was observed more frequently in diet groups in which psychological health was increased, but weight gain occurred in a short time. On the contrary, they stated that the healthy change in eating attitudes in groups that did not diet prevented weight gain again and spread over a long period. Accordingly, it can be said that the relationship between intuitive eating and eating attitudes is emphasized in the literature, but not discussed comparatively. The goal of this study is to compare the intuitive eating and eating attitude relationships with socio-demographic characteristics of people who follows and does not diet.

By the objective of the study, the hypotheses in the research are as follows:

- 1-There are significant differences between the sociodemographic characteristics of the groups and their intuitive eating and eating attitudes relationships.
- 2- There are significant differences between the intuitive eating and eating attitudes relationships in respect of the BMI classification of the groups.
- 3-There are significant differences between the intuitive eating and eating attitudes relationships according to the nutritional knowledge levels of the participants.
- 4- There are significant differences between the intuitive eating and eating attitudes relationships in accordance with the eating habits of the participants.

5- There are significant differences between the intuitive eating and eating attitudes relationships considering the physical activity status of the person.

Prevention and treatment effectiveness in problems with regard to weight and eating disorders will also be beneficial in determining intuitive eating attitudes. Within the scope of the target of this research, it will be examined as an innovative intervention to address the issues related to weight gain in a wide scope and to examine the intuitive eating method in this regard. It is hereby expected to contribute to the literature. Moreover, this research will further expand our knowledge of eating attitudes associated with intuitive eating in nutrition professionals. It is considered that increasing individual awareness of intuition and eating attitudes will also be clinically beneficial in practice.

2. GENERAL INFORMATION

2.1.Diet and Body Weight

Persons need more than forty kinds of food in order for their body to develop, differentiate and fulfill their functions. It has been proven by scientific data that when any of these foods are forgotten or taken less or more than the need, progress and development are under pressure and the health of the person begins to deteriorate. The fact that these foods are taken at an essential rate and used correctly in the body is defined by the term "adequate and balanced nutrition" (5). The goal in nutrition is to be able to get all the energy and food that people need compared to various external factors such as age, gender, exercise, and to be able to process and eat the foods, which are the source of the aforementioned, without losing their nutritional aspects and causing them to harm health (5). Nowadays, the role of nutrition in achieving people to reach their presence of growth and progress, and in preserving and regaining health becomes increasingly more and more important day by day. Disorders caused directly or indirectly by insufficient and unbalanced diet are observed, and the treatment of some ailments is provided only by diet. In some diseases, symptoms can be eliminated with diet. Due to this reason, the position of nutrition in conservative and therapeutic health services attracts more attention (7).

The most prominent ones among those directly caused by nutritional deficiency and imbalance are arteriosclerotic disorders, diabetes, hypertension, obesity, infectious disorders, dental disorders and liver disorders. Incomplete and unbalanced nutrition causes infectious diseases by reducing the resistance of the body, giving rise symptoms to occur that cause the disease to progress slowly and death (8). The linkage to diet and disorders around the world shows a series of differentiation. In the first period of the 20th century, the advanced affluent nations prevented the deficiencies of food (6) and the infectious disorders, and in the second period they encountered the disorders caused by the nourishment. Coronary heart disease, hypertension, cancer, osteoporosis and diabetes are in the forefront of these diet-related disorders. Obesity that becomes grounds for these diseases is one of the most important problems (5).

Obesity is a direct outcome of the proliferation of sedentary lifestyle (motor vehicles, electronic appliances and colorful life on the screen) and low-priced, high-energy food, which has rapidly increased in recent years. Obesity has generated an epidemic that has tripled in the last two decades, and this epidemic has been seen in many developed nations. It has been found out that this state is related to falling exercise rather than increasing energy consumption (9). It is stated that the three main factors that cause obesity are poor diet, less exercise and hereditary reasons. The consumption of foods with high energy content, low nutritional value, high amount of sugar and saturated fat, decrease in exercise has caused obesity to increase threefold in North America, England, Eastern Europe, Middle East, Pacific Islands, Australia and China since 1980. Obesity is a common problem of affluent and developing countries. Income level and the increasing of urbanization lead to the formation of a dietary pattern of high fat, trans fat and sugar. In addition to this, as the time passes by, working in jobs requiring less exercise is increasing (9). Body image and self-confidence are strongly related to body mass index (BMI). The level of attraction that women define for themselves is less compared to all other attraction meta views (9). Compared to men, women having high school and university education levels have got a higher level of perception than those who do not. Negative perceptions of weight are prevalent among both obese and healthy weight individuals, and changes emerge across social, financial and demographic groups (10).

Although it is stated that individuals express their personal body weight and height quite accurately, most of the obese men and women do not see themselves as obese (11). According to a study, the intrinsic impulse increased in those who ate without restriction, while decreased in those who restricted (12). Only 39% of men and 68% of women among people who are overweight consider themselves as being too overweight (11). The results reveal that it is necessary to develop brief, accurate and valid signs of perceptions and feelings about the body (11). In another study, 36.8% of women with obesity problems and 23.5% of very obese women stated that they see themselves at a normal weight (12).

2.2. Different Dietary Approaches

2.2.1 Mediterranean diet

The Mediterranean diet contains low amounts of red meat and saturated fat, high levels of grains, legumes, vegetables and fruits. In the diet where visible oil is used less, olive oil constitutes the majority of visible oil. Due to its rich fruit and vegetable content, it contains plenty of vitamin C, carotenoids, bioflavonoids, vitamin E, sulphurous compounds and similar antioxidants. It is rich in n-3 fatty acids on account of the green leafy herbs and vegetables it contains. The Mediterranean diet is also a very rich nutritional system in terms of omega-4 fatty acids (EPA-DHA) (5).

It is known that this diet has a protective aspect against heart diseases and cancer due to the underuse of saturated fat that raises blood cholesterol, and the preference of olive oil which is resistant to oxidation and does not raise blood lipids, and the frequent inclusion of alpha-linolenic acid, which prevents blood clotting, and antioxidants that prevent LDL cholesterol oxidation (5).

The main difference between the Western diets and the Mediterranean diet is the sources and rates of fats. Saturated fats and refined carbohydrates are commonly consumed in Western diets. On the contrary, in the Mediterranean diet, mostly unsaturated fats and olive oil are preferred. Extra virgin olive oils containing high levels of polyphenols and oleic acid have antioxidant and anti-inflammatory properties. It is also thought that the antiatherosclerotic property of olive oil can reduce endothelial damage and increase the regenerative capacity of the endothelium (5). Among its reasons, the Mediterranean diet also has the feature of preventing systemic diseases, thanks to the diet containing plenty of products containing antioxidant molecules such as fruits, vegetables and red wine. The Mediterranean diet sets the daily calorie intake along with physical activity. There is data in the literature showing that if the Mediterranean diet is applied for a long time, there is a decrease in the incidence of cardiovascular diseases and causes of mortality (6). In the consequence of in depth researches, evidences have been obtained that the Mediterranean diet is beneficial in protection against dementia and that the brain and cognitive process can be protected in the last stages of life as a result of long-term application of the Mediterranean diet (5).

2.2.2 Low Glycemic Index Diet

High glycemic index (GI) foods cause more increase in postprandial blood sugar and two-hour post-meal blood sugar compared to low GI foods. The World Health Organization recommends diets rich in carbohydrates (more than 55% of the energy source to be obtained from carbohydrates) with low GI, containing non-starch polysaccharides for a healthy life (7).

Foods with low GI are more filling than high ones. High-GI meals cause further decline and increase in the postprandial period, and increase the insulin level more. Therefore, on the advancing hours, fatty acids and blood sugar decrease at a higher rate and cause hunger. Low-GI foods, on the other hand, do not increase insulin too much, so it isn't observed big decrease in blood sugar and they don't cause hunger.

It has been determined that, thanks to the application of diets with low GI, people can be protected from the progression of colon cancer and breast cancer at a high rate. Since high-fiber and low-GI foods have a positive effect on postprandial blood sugar and weight control of diabetic patients, communities such as Diabetes Canada, Dietitians Association of Australia, and European Association for the Study of Diabetes also recommend low-GI diets (7).

Low GI diets reduce the insulin hormone and increase energy. In addition, thanks to the diet, fat storage decreases and the existing fats in the body are started to be burned, and, as a result, weight loss occurs. A significant decrease was observed in the body mass index of obese children who consumed foods with low GI. Weight loss in a low GI diet occurs through two main mechanisms:

- 1- Increase in satiety
- 2- Increase in fat burning

Low-GI foods provide long-term satiety, allowing you to eat less at the next meal. When the GI ratio increases by 50% in a meal, there is a 50% reduction in the feeling of satiety. The increase in the feeling of satiety is directly proportional to the increase of cholecystokinin hormone secreted by the intestine.

The GI diet is more beneficial than other diets with its ability to break insulin resistance. Diets below 1200 calories increase insulin resistance, causing weight gain. In order to lose weight, it is necessary to prevent being hungry and tending to eat desserts. This is possible with the consumption of low glycemic index foods (7).

Diets with very low amounts of fat, calories and carbohydrates do not suppress the feeling of hunger and result in weight gain. On the other hand, in a low-GI diet, there is no starvation or a diet based on a single food type.

The main benefits of a low-GI diet are listed as follows:

- 1- Feeling sluggish after meals, loss of energy and fatigue in the afternoons are eliminated. The cause of fatigue and loss of energy is the fluctuations in insulin and glucose that occur after meals. If the brain gets enough glucose, you will concentrate and the feeling of tiredness disappears.
- 2- Prevents type 2 diabetes, heart diseases, depression, high blood pressure and some types of cancer.
- 3- Improves the quality of sleep.
- 4- Hunger crisis become rare and disappear.

Hunger occurs as a result of the body's need for food. However, it is not normal to feel hungry when this need is not in question. Eating unnecessarily causes weight gain. The reason for this type of abnormal hunger attacks is the fluctuation of insulin in the blood. High-GI carbohydrate consumption causes rapid increase in blood glucose and insulin and then fall below normal, causing hunger. The same situation repeats itself if you consume something sweet. If foods with low-GI are consumed during hunger, hunger crisis start to become sparse.

Stress is also one of the factors that cause unnecessary hunger crisis. The reason why people turn to sweet foods in times of stress is that sweets cause an increase in the happiness hormone called serotonin in the brain. The hormone cortisol, increasing due to stress, causes a decrease in serotonin. Individuals with poor sleep quality often experience hunger spells due to insufficient serotonin (7).

For a healthy diet, it is necessary to pay attention to the satiety index of foods. Foods with low energy density provide a quick feeling of satiety. Examples include foods such as pasta, apples, potatoes, and oranges. On the contrary, foods such as chocolate and peanuts provide less satiety. Another factor that determines the degree of satiety is the GI level of the food. Low-GI foods stay longer in the small intestine and lead to long-continued satiety. On the other hand, foods with high-GI increase hunger as they increase and decrease blood glucose rapidly. Stress hormones such as adrenaline and cortisol also rise as a result of the rapid drop in blood glucose and the feeling of hunger increases. The glycemic index is used to balance fluctuations in blood glucose and improve glycemic control. The slow release of glucose into the bloodstream and the reduction of insulin release minimizes glycemic variation. Conversely, foods with a high glycemic index also cause a sudden increase in blood glucose concentrations and insulin response (7). This situation also causes an increase in the risks of certain types of cancer.

Food consumed affects blood glucose levels. Low-GI foods can cause low blood sugar and insulin responses in normal individuals and improve glycemic control in patients with controlled diabetes. The goals of improved glycemic control are to reduce the need for medication, reduce the possibility of diabetic complications, and increase the quality of life and life expectancy. Recent studies have shown that a low-GI diet can be beneficial, especially in diabetic patients (8).

2.2.3 DASH Diet

The DASH (Dietary Approaches to Stop Hypertension) model is especially used to reduce cardiovascular disease risks. DASH is a diet rich in low-fat dairy products, whole-wheat grains, fruits, vegetables, white meat and nuts. In this diet, where a small amount of red meat is allowed, refined foods, carry-outs containing sugar, and foods rich in saturated fat and cholesterol are not included (9).

The main purpose of the DASH diet is to prevent or cure hypertension (high blood pressure) and to build up a lifelong healthy diet. Salt (sodium) consumption is reduced

within the diet and foods that will provide low blood pressure (foods containing calcium, magnesium, potassium) are preferred.

As long as the diet is followed regularly, it is possible to reduce the blood pressure by a few units in as little as two weeks. As a result of continuing the diet, the blood pressure can decrease to 14/8 and thus the person can be protected from various health risks (9).

With the help of the DASH diet, the likelihood of osteoporosis (bone resorption), heart disease, cancer, diabetes and paralysis can be reduced. Weight loss also occurs thanks to the healthy foods contained in the diet although the purpose of the diet is not loss in weight.

The sodium level consumed while applying the DASH diet is very important. Sodium is a substance that increases blood pressure significantly, and high blood pressure can also give rise to extremely serious effects. In the DASH diet model, sodium consumption can be reduced by two different methods: Standard DASH diet and low sodium DASH diet.

Within the standard DASH diet, 2300 mg sodium consumption per day is free. However, the daily allowable sodium amount in the low sodium DASH diet is limited to be 1500 mg. Both methods provide lower sodium intake compared to diets containing 3500 mg and above sodium on average. For the sake of protecting cardiovascular health, the recommended daily sodium intake is specified as 2300 mg at most. In both methods, whole-wheat grain foods, fruits, vegetables, low-fat milk and dairy products, white meat and legumes are consumed. But besides to these, red meat, sugary foods and fat are foods that can be consumed in limited quantities (9).

2.2.4 Ketogenic Diet

The ketogenic diet model is a diet rich in fat, low carbohydrate and sufficient protein. By keeping carbohydrates at insufficient levels in the diet, fats are used as the

main energy source. Carbohydrate is converted into glucose and then turned into energy for the brain. In low-carbohydrate diets, the liver converts the fat taken into fatty acids and ketone bodies. Ketone bodies are moved to the brain and replace glucose as an energy source. The ketogenic diet model has been seen as an effective treatment for diseases such as brain tumors, childhood hemiplegia, migraine, autism and epilepsy since the 1920s (10). The effect of the diet in question, that causes weight loss in obese individuals may also affect metabolic mood syndrome (10).

The ketogenic diet is also known for its antioxidant and anti-inflammatory effects. Ketone bodies can also be used in the production of adenosine triphosphate (ATP). The ketogenic diet is associated with changes in different monoamines, including dopamine, noradrenaline, and serotonin, in relation to neurotransmitters, and thus providing a therapeutic effect on mood state changes (11). Specially designed meals mainly include foods with low carbohydrate and high fat content, excluding heavy cream, pastrami / cured spiced beef, eggs, tuna fish, shrimp, vegetables, mayonnaise, soudjouk, sausage. Epilepsy patients should avoid starchy vegetables and fruits and foods containing simple sugars such as bread, pasta and pastries. It is claimed that this diet model may have side effects such as constipation, fluid loss and hunger deprivation.

2.2.5 Intermittent Fasting

This model, consisting of limited feeding periods, has been prepared by observing religious and spiritual traditions such as Ramadan fasting. During the Ramadan fasting, calorie and water consumption are avoided from sunrise to sunset. The main benefits of this model, such as weight loss and improvement of lipid profile, have had a scientific and popular impact. Studies have sought answers to the questions of what physiological mechanisms this diet triggers for weight loss and improving lipid profile (14). When intermittent fasting is applied in addition to normocaloric and hypocaloric diets in obese and dyslipidemic individuals, total cholesterol, triglycerides and LDL decrease and HDL level increases. Intermittent fasting diets were applied as two different alternatives in randomized control studies. The first alternative is a high-carb low-fat diet while the other is a low-carb high-fat diet. As a result of both diets, a decrease in total cholesterol, LDL, triglyceride and weight was observed (14). It is claimed that intermittent fasting diet regulates metabolism through its effects on circadian rhythm, gastrointestinal microbiota

and way of life. When an adverse situation rises in these systems, the person develops a metabolic environment that may cause diabetes, cardiovascular diseases or cancer. The intermittent fasting diet has a direct effect on the gut microbiota, being various microbial communities in the intestines. Studies have shown that changes in the function and composition of the gut microbiota in obese individuals may result in higher energy expenditure compared to lean microbiota and consequently the storage of net energy intrasusception (15). Most of the analysis on the subject are done through observation, though, they do not provide detailed information about the diet. Randomized clinical studies with large samples are required to evaluate intermittent fasting diets in patients with dyslipidaemia (15).

In intermittent fasting diets, the main energy source is identified as keto rather than glucose. Glucose and fatty acids are essential energy sources for cells. While glucose taken postprandial is used for energy, fat taken is stored as triglycerides in adipose tissue. During hunger, triglycerides are split into fatty acids and glycerol, and the liver converts fatty acids into ketone bodies during fasting. The ketone body is a great source of energy for many tissues and especially the brain in intermittent dieting. Blood levels of ketone bodies are low in the diet, but rise within 8 to 12 hours after the onset of hunger. A level between 2 and 5 mm may be observed in a 24-hour period (13).

The most frequently preferred intermittent fasting regimens are as follows: Fasting 24-hour a day, 2 days a week, and time-limited nuourishment on other days; 24-hour fasting and diet in which calorie intake is significantly reduced (such as 500-700 calories per day) for 1 or more days per week. These systems are called alternate day fasting diets. The ketone levels in the blood rise on fasting days (13).

Low-calorie diets enable the use of fatty acids and ketone plots after glucose as a fuel source and efficiency of energy production.

Ketone bodies are not only fuel used during fasting, but also powerful molecules that have significant impact on cell and organ functions. These molecules regulate the activity of many proteins and molecules known to positively affect health and slow down

the aging process. It is also known that these molecules stimulate neurotrophic factor gene expression, known for its effect on brain health, psychiatric and neuro-degenerative diseases (13).

Studies have also shown that intermittent fasting diets have various benefits other than weight loss. Examples of these benefits include improvements in glucose regulation, heart rate and blood pressure, increased endurance and abdominal fat loss.

2.3. Emotional Eating

Emotional eating is defined as binge eating tendency in response to negative feelings. It is known that emotional eating tendency gives rise to many serious psychological and physical consequences. Eating disorders such as binge eating and bulimia nervosa have a significant relationship with depression, emotional nutrition and accordingly, increased weight. Studies on emotional eating have focused on the effects of negative emotions such as stress on binge eating. Failure to understand the difference between emotional arousal and hunger signals leads to binge eating behavior (16).

The increase in the level of stress may bring about emotional arousal, and this arousal can cause people to be unable to distinguish between hunger and satiety cues. Studies on this subject have shown that people report more hunger during their stressful periods (16).

Emotions have a serious impact on eating habits and food choices. Some people may head towards reactively to emotional eating in the face of negative emotions such as anxiety, depression, anger, and loneliness. Such type of negative eating behaviours may cause disorders such as obesity, binge eating, and bulimia nervosa (17). In the event of emotional eating crisis, the person often turns to sugary and fatty foods as a comforting food. As a result of neuroendocrine studies, it has been observed that comforting foods reduce stress levels, suppress negative feelings and improve mood by increasing dopamine levels (18).

Emotional eating is a acquired behaviour. Negative feelings act as triggers and direct the person to eat. Some emotional eaters turn to food because of the improvement

in their negative emotions for a short time after eating. Therefore, in due course, emotional changes lead to further deterioration of eating behaviors. The fact that the person turns his/her focus to food in the face of negative emotions and thus into an instant, concrete and physical stimulus, and that thoughts related to emotions are prevented through low self-awareness activities, is explained by the concept of escape theory (18).

Depression may be the result of seasonal emotional disorders and changes in carbohydrate quality consumed during premenstrual syndrome (PMS), neurological functions and moods. High carbohydrate intake leads to increase in glucose, which is the main fuel source of the brain, and in this case, serum tryptophan concentrations and its effect on serotonin synthesis are also increased (19).

Emotional arousal, regardless of whether it is positive or negative, is considered to have a direct effect on eating behavior (4,5). Negative emotions or physiological reactions observed in the state of stress resemble the feeling of satiety after a meal, so negative emotions, causing loss of appetite, is considered a natural physiological response (6). Tendency to eat in the face of negative emotions, on the other hand, is named as emotional eating and accepted as an inappropriate reaction (7). It is known that the binge eating response during negative emotion is observed in obese individuals (8), women with eating disorders (9) and individuals who are dieting even though they are at normal weight (10,11). Because of these facts, it is thought that the relationship between emotions and eating is partially related to some personal characteristics (5, 6).

Various theories have been developed on the relationship between eating and emotions. According to the psychosomatic theory, which is one of them and developed in 1973, the act of binge eating is associated with false awareness of hunger. According to the theory, the individual cannot understand neither his/her hunger nor his/her satiety, and tends to the act of eating in response to his/her emotions, not to stimuli such as appetite, hunger, satiety. Those people who do not have the right internal programming impulse for hunger awareness need external signals to determine when and how much they eat (33). According to Kaplan's (34) theory, obese individuals tend to overnourishment so as to reduce their anxiety when they are nervous or stressed. Obese

people, who cannot distinguish between feelings of hunger and anxiety, respond to anxiety as well as hunger with eating behavior. According to Schachter's internal/endogenous & external/exogenous theory, while physiological symptoms caused by emotions such as fear and anxiety cause a decrease in food consumption in people with normal weight, this situation does not occur due to insensitivity to internal/endogenous stimuli in obese individuals. In the external/exogenous eating theory, the individual is not sensitive to internal/endogenous hunger and satiety. The biggest difference of the external/exogenous eating theory from the psychosomatic theory is that the eating event causes a new start. The food perception of the individual in the external/exogenous eating state is present only when they are in the same environment with the food. They tend to overeat by being influenced by the smell or appearance of food, but they do not have a food-focused perception in external situations (35). In the containment theory developed by Lowe et al. (36), there is a person's desire to overeat for foods and his/her cognitive restriction effort against this desire. These type of individuals complain that they eat too much and try to restrict their eating habits in order to avoid gaining weight. However, the restriction here is not a restriction on nourishment as much as needed during eating, but a restriction that includes an effort to eat below the desired amount.

The restrictive actions of people of normal weight are aimed at maintaining their normal weight rather than losing weight. When the restrictive eating action continues for a long time, it may leave its place to binge eating attacks (37). This situation is usually observed in people who limit their daily calorie intake in order to maintain their weight. Self-control in those fed with a restricted attitude may be temporarily disrupted in situations such as anxiety and depression (37). People with restrictive eating behaviours may be more prone to hyperphagia during stress than those who do not (37).

Emotional eating is considered as a psychological support used to deal with negative emotions. Binge eating attacks can be observed in individuals who have difficulty in identifying or understanding emotions. People, living their emotions intensely, may have the feeling that they cannot cope with this emotional state when they find it difficult to perceive what their emotions really mean. For example, while the sentence "I am not feeling well" has a general meaning, the sentence "I feel anxious and under stress" is a more detailed expression of emotion. In cases where individuals have

difficulty expressing their emotions, they may turn their attention to the act of eating in order to escape from this disturbing situation and exhibit a kind of escape action (38). It is also claimed that there is a strong relationship between the increase in stress-related eating and the reward system.

2.4. Functional Nutrition

Functional foods are defined as foods that have positive effects on physical functions, improve health status and reduce the likelihood of disease. Such foods are consumed for purposes such as preventing chronic diseases or improving health. Probiotic-enriched yogurts are one example of these kind of foods (20). Functional nutrition can also be a part of a social interaction. The distinguishability of functional foods is a reason for preference for conscious consumers. It is suggested that the self-control motivation perceived thanks to this distinguishability has an intuitive function such as controlling themselves or applying a general hedonic motive in individuals. The consumers in question find the distinguishability of functional foods positively and may prefer these products as an easier and faster alternative instead of focusing on a balanced diet or effortful exercises. Characterized as socially and culturally popular in our age, functional foods help the consumer to make a positive impression on others. The consumer defines himself / herself with the product he / she bought and shows himself / herself to others as a modern and healthy person. Health conscious consumers approach functional foods positively, as they are more motivated to improve and protect their health by turning to potentially healthier foods. Since functional foods offer an easy solution for a healthy life, the low level of perceived self-control motivation of the consumer will increase the tendency towards functional foods (21). Behaviour control reflects the sense of self-efficacy in the person. This situation is related to the ability of the person to choose healthy foods, and in this respect may be related to their motivation to control. The short-term prevention of socially unacceptable impulses refers to the capacity of the person to change and regulate his/her behaviour (22).

Functional foods are not products that are clearly defined or whose properties are clearly defined. It is possible to evaluate many foods as functional. This concept is mainly used to describe foods that positively affect health and reduce the risk of disease. Functional foods are defined as foods or components that provide benefits on human metabolism and physiology beyond meeting the basic nutritional elements required by the body and have an effect on the person to make them healthier.

Functional foods are prepared by methods such as increasing one of the beneficial ingredients, adding health-beneficial ingredients, separating potentially harmful ingredients from food, chemically modifying various ingredients or increasing bio-efficacy, or applying similar combinations. Such foods should not be in the form of drugs, capsules or dietary supplements and should not have an allergic effect. Functional foods should be scientifically proven, nutritionally adequate, have characteristics such as improving one or more functions in the body or reducing the risk of disease, and should be a part of a normal food consumption model and reliable (23).

Perspectives on functional foods vary from country to country. Some countries in the Asian region, especially China and Japan, are places where the border between medical and food sciences have been discovered for the first time. Japan is the birthplace of the concept of functional nutrition and is a leader in the development and regulation of this industry. The concept of functional food was first adapted from the concept "Nutraceutical" in the USA after the joint campaign of "Kellogg Company" and "National Cancer Institute" on the prevention of cancer of certain fibers, especially wheat bran fiber, in the early 1980s, and Japan has developed a new concept by modifying it. In the early 1980s, three comprehensive studies were conducted on the subject, also supported by the Japanese Government. The policy on commercialization of functional foods was first adopted in Japan in 1991. These foods have been regulated by the FOSHU (Foods for Specified Health Uses) law and the FOSHU license has been made mandatory. In the West, progress has been made later, due to the absence of specific laws or appropriate policies. An interest in these foods has started in Europe and the USA since the 1990s, and wide-ranging and high-participation projects such as FUFOSA and PASSCLAIM have been initiated since 1996. The FDA (Food and Drug Administration) accepted a

number of health claims related to functional foods in 1998 (24). In Turkey, functional nutrition is a very new topic, and as there are few studies on the subject, functional foods have a low market share and have no legal dimension (25). 5% of the total food expenditure of developed countries consists of functional foods.

A total of 1700 functional food products were put on the market in Japan between 1988 and 1998. The market, which was between 7 and 10 billion dollars in the USA in 1995, increased to 15 billion dollars in 2000. The leading countries in the functional food market are the USA, Japan and European countries. It is estimated that the functional food market will reach a rate of 5-20% of the whole food market in the world with the increase of the expectations to increase the quality of life in people. Among the most popular functional foods today are probiotic yogurt and beverages, various herbal teas, DHA (docosahexaenoic acid) containing snacks, foods high in dietary fiber, products with reduced energy (such as fat-free - low-fat dairy products, sugar-free chewing gum, beverages and confectionery), foods containing omega-3 fatty acids, gluten-free breads and pastas, sportsperson foods (energy drinks), enriched foods (such as calcium-rich milk, iron-rich bread), phytosterols and modified margarine products containing plant stanol esters (26).

Functional nutrition is in demand in our country more and more day by day, and a functional food market worth about 150 million dollars is in question in Turkey. Manufacturers compete with each other to take part in the market of Turkey with high potential. The introduction of a different product to the market every day indicates that the growth will continue. It is estimated that the functional food market will also become increasingly active as people give importance to healthy nourishment and the awareness in this direction increases. In this market, which gains traction of investors due to its high potential, it is expected that there will be a great competition in the coming years. In Turkey, the first product that attracted attention in the field of functional food was margarines that help lower cholesterol. Functional dairy products (such as probiotics, prebiotics, and kephir/kefir) have a market share of \$ 42 million. Herbal teas, diet and fiber foods have also recently begun to attract great attention (26).

2.5 Intuitive Eating

The concept of intuitive eating was defined as a non-dietary approach by two clinical dietitians Evelyn Tribole and Elyse Resch in 1995. According to Resch and Tribole, this method is a bridge between an unconventional dietary approach and a typical public health approach that includes diet to reach ideal body weight (27). Intuitive eating is a form of eating in which a person gives ear to the body's natural hunger and satiety signals and acts accordingly. Other names used for this concept in the dietetic field include the no-diet approach (nondiet approach), regular eating, adaptive / consistence eating (adaptive eating), smart eating (wisdom eating), and conscious eating (conscious eating). Intuitive nutrition is a harmonious diet model based on eating in accordance with the body's hunger and satiety cues (27). The basic principle in intuitive nutrition is to attain body wisdom (28).

In an intuitive diet, it is a matter of basically knowing the type and amount of food that the body needs, which is developed on weight control independently of a particular health problem (27). The basic eating behavior that occurs when the person satisfies the physiological hunger and stops eating before reaching the over-satiety phase after adequate nutrition is the intuitive diet. The main approach in intuitive eating is that if the person does not have a chronic disease, they can instinctively choose the types and amounts of food that they will establish their own nutritional balance and thus do not impose any restrictions on the variety of food consumption (29). Intuitive nutrition is associated with positive body image, regular nourishment, emotional functionality, and various psychosocial factors (30).

There are three main approaches to intuitive nutrition:

- 1- Allowing to eat unconditionally (eating time and food selection),
- 2- Eating for physical rather than emotional reasons,
- 3- Nourishment according to the body's signs of hunger and satiety (31).

Unconditionally allowing a person to eat means consuming whatever food he wishes at the time of physical hunger. People, following this diet, only act on signs of

hunger, without worrying about what and how much to eat. It is known that the individual does not tend to overeat in eating behavior that is controlled only according to physical hunger and satiety signals (27). The underlying cues in intuitive eating are physical rather than emotional, so in intuitive nourishment one eats to satisfy physical hunger, not to cope with emotions (28). People who do not practice intuitive nutrition end their eating behavior when they reach emotional satisfaction. It is known that intuitive nutrition develops through an innate awareness and that the person acts with the principle of “eat when hungry, stop eating when full” (27). According to Resch and Tribole, who developed the concept of intuitive nutrition, there are ten basic principles of intuitive eating: "rejecting the diet mentality", "being honored by the feeling of hunger", "making peace with food", "opposing the food police", "feeling satiety", "discovering the satisfaction factor", "experiencing the emotion felt without heading for food", "respecting your body", "feeling the difference by exercising", "honoring your health and eating permissively". By adopting a diet based on these principles, it is aimed to break the taboos on diet and to reveal the innate intuitive nutritional instincts of the human being. In this way, it will be possible for a person to achieve a true harmony of body-food-mind (32).

The intuitive eating scale is used to evaluate harmonious eating as an alternative to irregular eating habits (27). In 2004, the first intuitive nutrition scale was developed by Hawks et al. Tylka handled this scale on three sub-factors in 2006.

2.6 Intuitive Eating, Body Weight And Bmi (Body Mass Index) Relationship

Intuitive eating behaviour is considered as an alternative approach that focuses on physical hunger and gives clues about what food to consume and how much, and it is accepted inversely related to body weight-body mass index (BMI). Hence, it is a supportive approach for the prevention and recovery of obesity (39). Considering the effect of intuitive nourishment, which emphasizes focusing on hunger and satiety signals to regulate eating habits, on environmental factors such as plate and portion sizes, it was observed that there was a direct proportion between high intuitive eating level and low food consumption (40). It was seen they preferred the intuitive nutrition model more than traditional practices when the knowledge and attitudes of dieticians on the use of intuitive nutrition and traditional - restrictive diet models were examined (40). Intuitive nourishment

is accepted as a healthier eating habit compared to different models in respect of maintaining the variety of nutrients required for the body to instinctively maintain its health (40). In studies examining the relationship between BMI and intuitive nutrition in young adults, it was also found that intuitive eating was inversely proportional to BMI, those who ate intuitively were 40% less likely to be exposed to excessive body weight control behaviours, and dieting was less likely than those who did not intuitively eat (41, 42).

2.7 The Relationship Between Intuitive Eating and Eating Attitudes

The main purpose of national health planning is to build up a healthy society composed of healthy people. Increasing the quality of health services is not sufficient for a healthy life. Being aware of their personal health, it is also necessary for people to request health services and show a difference in action in a positive direction. In particular, people have important responsibilities in terms of protection from obesity, which is among the most important health problems of today (43). Obesity treatment is a compulsory, long and continuous period that requires the person's tenacity and active participation. The fact that many factors are active in the etiology of obesity makes the prevention and treatment of this ailment very difficult and complex. The purpose in obesity treatment is to reduce the risk of morbidity and mortality related to obesity, to provide the person with an adequate and balanced eating practice and to increase the quality of life of the person by aiming at a proper weight loss. Accordingly, it is important for the person to be aware of the eating behavior and to show actions that will manage their health. (44).

The concept of Intuitive Eating was introduced by Tribole and Resch in 1995 (37). Intuitive eating is expressed as the harmony of cognition, body and food established with a dynamic period. It refers to an adaptive eating style based on hunger and satiety in order to regulate food consumption (45).

On condition that the body is given ear to, the essentials of intuitive eating is that it provides the body with the awareness of the amount and type of food to be taken due to its nature in order to maintain both health and the correct weight in terms of food intake. This concept is sometimes stated as "body wisdom". The social signs that work to eliminate the innate state of body wisdom are as follows: diets, a child cleaning up his

plate, you have to eat because it is "dinner time" and ads that constantly direct people to food regardless of hunger. The basic conditions of intuitive eating are to reacquire "body wisdom" so that the person will often eat when they are hungry and stop when they are full. There is no restriction on the types of food that a person may consume, as long as a specific health problem does not force it (e.g., diabetes, food allergies), since the body intuitively prefers various foods that constitute the balance of eating (46).

The concept of intuitive eating is expressed in the way of relying on physical precursors to approve what time, what and to what extent a meal should be eaten. While a healthy relationship between food, cognition and body continues, intuitive consumers pay attention to the sensations and pleasures arising from food. Intuitive eating basically consists of ten criteria recommended by Tibalo & Resch: 1) raise objection to the logic of the diet, 2) honor your hunger feeling, 3) do not be cross with food, 4) oppose the food police, 5) respect the feeling of satiety, 6) bring out the satisfaction factor, 7) honor your feelings without consuming food, 8) respect your body, 9) do sports- feel the difference, 10) honor your health - tactful nourishment (37).

It is stated that the intuitive eating skill is innate (37). Babies try to advance their food choices and eating practices after their birth, as the mother makes a decision about breastfeeding and giving baby formula. While breastfed babies have to taste the different flavors brought by their mothers' food, babies fed by formula have to taste only one food. As a result, breastfed babies can take solid foods more easily than babies who take formula (47). If the caregiver creates a space with strict eating rules or forcing children to eat, then, children may not be able to follow the core precursors of hunger and satiety (48,49). When it is difficult for calorie intake, infants and children can organize their calorie consumption by following their self-instructions (50,51). However, parental control and other factors make the validity of these impulses ineffective, therefore, it is stated that it reduces the sensitivity to the core precursors. Eneli et al. states that when caregivers do not understand the definition of normal weight correctly and limit consumption, when the child does not want to eat food, when they are forced to eat, and when caregivers use food to comfort them, there is interference in the progression of confidence in the precursors of children such as hunger and fullness, appetite, (52).

It is stated that intuitive eating can be a correct method for the prevention and treatment of obesity (53). The intuitive eating method, when compared to conventional

weight loss plans, motivates the person in some cases, and can show a different method that is uncoercive in respect of obese people by encouraging them to lose weight (54). However, there is also the idea that diet planning based on energy limitation is a better method than intuitive eating practice in terms of weight management (55). Along with these, it is stated that intuitive eating can be an integral point of view regarding camiller women's personality perception (56). In a study conducted with university students, it was concluded that intuitive eating is negatively related to eating disorder symptoms, body discontent and absorption of the desire to be weak, and positively correlated with well-being (57).

In a study examining the knowledge and attitudes of 22,542 dietitians about intuitive eating and the application of classical / restrictive diet techniques, it was stated that most of the dietitians (76.9%) had knowledge about intuitive eating and that dietitians applied the intuitive eating method more than classical weight control practices (58). Intuitive eating is not basically aimed at facilitating weight loss easy, but by restoring the innate but interrupted eating ability to advance people's correct eating behaviours (59).

Unconditional permission to eat indicates physical signs of hunger and the desire to eat the currently desired food (57). People involved in this eating technique, who do not try to postpone the symptoms of hunger, are neither grouped in a way that they can consume and can not be approved, nor do they try to avoid unapproved foods. Laboratory experiments have found that these people ate more food after a period of time without food or after consuming a small amount of food rather than a large amount of food (60). Therefore, their food intake is managed in terms of hunger and satiety symptoms differently from those who allow them to take food but do not have the will to eat (eg, people who eat excessively) (57).

Individuals who are determined to consume when, to what extent and what kind of nutrients (restricting the time, size and type of food to be taken according to some external criteria) are more likely to be into food and feel deprivation (57). It has been found out that when a significantly reduced calorie diet was applied to men who had not dealt with food before, for six months, many of them were intensely stuck in food and had overeating movement that continued even after the diet was over (61).

It has been stated that children whose food consumption is restricted by their parents are more likely to consume food when they are not hungry and have more body mass than

children whose food consumption is not restricted by their parents (62). It has been stated that individuals who take restrictive food are more sensitive to food precursors (smell, taste, etc.) than those who do not consume restrictive food, and this state increases their food consumption (63). Dietary restriction further increases the nutritional effort. This is because people who limit their food intake essentially consume more food than people who are unconditionally allowed to eat (64).



3. MATERIALS AND METHOD

3.1. Place and Time of Research

This study was planned on 100 adult volunteers between the ages of 25-55 living in İstanbul-Bayrampaşa and applied to Bayrampaşa Municipality Health Affairs Directorate for nutritional counseling and 100 randomly selected volunteers who do not follow any diet program in order to evaluate the intuitive eating and eating attitude relationship. The study was carried out by the Yeditepe University Clinical Research Ethics Committee with the Ethics Committee Approval (Annex-1) dated 07.05.2020 and numbered 1218.

3.2. Selection of the Research Population and Identification of Individuals

People who applied for the purpose of losing weight, between the ages of 25-55 to Bayrampaşa Municipality Health Affairs Directorate applied for the study between 30.04.2020 and 31.05.2020.

100 people who voluntarily agreed to participate in the study, who did not have any psychological health problems that would affect the study, were included. In addition, 100 people those who do not receive any Professional support on diet attended. Thescope and objectives of there search were explained in detail to the individuals included in the study, and the consent form was filled voluntarily. Individuals diagnosed with any psychological health problem before orduring the study were not included in the study.

3.3. Data Collection and Evaluation

The research started on 30.04.2020 with the approval of the ethics committee of Yeditepe University Clinical Research Ethics Committee.

A questionnaire containing general information was applied to determine the personal characteristics of the participants. The questionnaire contains information on the demographic characteristics of individuals (age, educational status, employment status, etc.). Intuitive Eating Scale and Eating Attitudes Test were applied to the participants by one-on-one interview technique.

Height and body weight were determined from anthropometric measurements of the participants and body mass index (BMI) was calculated.

3.3.1. Evaluation of Anthropometric Measurements

The body weight of the participants was measured using standard scales without shoes. The height of the participants were measured with a measuring tape in the frankfort plane at the upright posture, with the feet side by side and the heel and the occipital area touching the wall.

Body mass index (BMI): BMI is calculated by dividing body weight by square meters of length, body weight (kg) / length² (m).

3.3.2 Intuitive Eating Scale

Intuitive eating scale is the first scale to be used to collect data in the dissertation. The original intuitive eating scale-1 is a scale composed of 21 items and three sub-dimensions by Tylka (39). The Intuitive Eating Scale-1 was reviewed by Tylka and Kroon Van Diest (41) and the Intuitive Eating Scale-2 version was developed. Intuitive eating scale-2 (IES-2) was adapted to Turkish by Başı et al. (65). The Cronbach α coefficient of the scale was stated as 0.82. The scale consisting of 23 items examine intuitive eating in 4 sub-dimensions. These are: 1. Unconditional eating leave (when s/he is hungry and what food s/he desires (6 questions)) 2. Eating for physical rather than emotional reasons (8 questions) 3. Eating based on hunger and satiety signals (determining when and how much to eat (6 questions)) 4. Body nutrient selection compatibility (3 questions). In this study, the Cronbach α coefficient was stated as 0,763. The median of the study was 3,3.

3.3.3 The Eating Attitude Scale

The other scale to be used, the eating attitude scale, measures possible disorders in individuals' eating behaviours. The total score obtained from the scale indicates eating disorder (66). It is a 6-point Likert scale type consisting of 40 items. A score between 30 and 32 on the eating attitude scale indicates a situation that is not diagnosed with eating disorder symptoms but different from the others in terms of eating attitude. Getting 33 points or more indicates pathological eating symptoms (66). The Turkish adaptation was made by Savaşır and Erol (67) and the reliability coefficient was reported as $\alpha = .65$.

3.4 Statistical Analysis

The data found as a result of this study is IBM SPSS Statistics 22 (Statistical Package for Social Sciences for Windows 22) computer program evaluated. Descriptive statistics percentage (%), mean ($\bar{X}$), and standard deviation. It is expressed with (SS) values.

For statistical significance $p < 0.05$ was accepted. Mann Whitney U statistical test was applied in cases not suitable for normal distribution. The Kruskal Wallis test was used to compare more than two non-normally distributed measurements. Because of the data is not normally distributed, Spearman correlation analysis was applied.

4. RESULTS

4.1. Demographic Information

Table 4.1 contains the distribution of descriptive characteristics of participant.

While 69% of participants were women (n=139) 30% participants were men (n=61). And the mean of age of participant was 34.24.

While, 46.5% (n = 93) of the cases were married, 46.0% (n = 92) were single, 2.5% (n= 5) were widowed and 5.0% (n = 10) is divorced.

When the educational situation is examined; It was observed that 12.0% (n = 24) were primary education graduates, 19.5% (n = 39) high school graduates, 55.0% (n = 110) university graduates, and 13.5% (n = 27) postgraduates.

For mother education status, mostly 55.0% (n=110) participants' mother were graduated from primary school. Therewereonly 3.0% (n=6) participants' mother were post graduated.

For father education status, mostly 52.5% (n=105) participants' mother were graduated from primary school. There were only 4.5% (n=9) participants' mother were post graduated.

64.5% (n=129) participants were working, while 32.0% (n=64) participants were not working. 3.5% (n=7) of them were retired.

For the income status, mostly they mentioned middle income with 80.5% (n=161). 9.5% (n=19) of participants stated low income while 10.0% of them have high income.

27.5% (n = 55) of the cases have a medical illness. When medical illness types are examined; 3.5% (n = 7) diabetes, 3.5% (n = 7) cancer, 2.0% (n = 4) cardiovascular disease, 1.0% (n = 2) kidney disease, 4.5% (n = 9) cholesterol, 3.5% (n = 7) hypothyroidism and 5.0% (n = 10) blood pressure and lastly 5.5% (n=11) stomach diseases.

While 9.0% (n= 18) participants have psychiatric illness, 91% (n=182) of them have not. Only 30.5% (n=61) of participants have used medication.

While the rate of smoking cases is 29.0% (n=58), 71% (n = 142) do not smoke. While the rate of alcoholuse is 80.5% (n=161), 39% (n = 39) do not.

52.0% (n=104) of participants never did diet. 30.5% (n=61) of participants stated that 'I did it 1-4 times', 5.0% (n=10) stated 'I did it 5-10 times', 4.5% (n=9) stated 'I didmorethan 10'. 7.5% (n=15) stated 'I do it constantly'.

93% (n = 186) of the respondents have not been diagnosed with sleep disorder. Only 17% (n=14) of respondents have been.

When the consumption amount of water is examined; 6.5% (n = 13) of the cases 2 cups and less per day, 27.0% (n = 54) 3-5 cups, 24.5% (n=49) 6-8 cups, 26.0% (n= 52) 9-12 cups and 16.0% (n = 32) consume 12 + cups.

40.5% (n=81) of participants do not do regular physical activity. 36.0% (n=72) of participants stated that 'I do it 1-2 per week', 14.5% (n=29) stated 'I do it 3-4 per week', 9.0% (n=18) stated 'I do that every day'.

Table 4.1 Distribution of Descriptive Characteristics of Participants

Variable		n	%	$\bar{x}$ (Ss)
Gender	Woman	139	69	
	Male	61	30	
Age		198	99	34.24 (11.03)
Marital status				
	Single	92	46.0	
	Widow	5	2.5	
	Married	93	46.5	
	Divorced	10	5.0	
Education				
	Primary school	24	12.0	
	High school	39	19.5	
	The University	110	55.0	
Mother Education Status				
	Literate	35	17.5	
	Primary school	110	55.0	
	High school	34	17.0	
	The University	15	7.5	
	Postgraduate	6	3.0	
Variable		n	%	$\bar{x}$ (Ss)
Father Education Status				
	Literate	17	8.5	

Primary school	105	52.5		
High school	42	21.0		
The University	27	13.5		
Postgraduate	9	4.5		
Working Status				
Working	129	64.5		
Not working	64	32.0		
Retired	7	3.5		
Income				
Low	19	9.5		
Middle	161	80.5		
High	20	10.0		
Medical Illness Status				
Yes, I'm	55	27.5		
No	145	72.5		
Medical Illness				
Diabetes	7	3.5		
Cancer	7	3.5		
Cardiovascular Diseases	4	2.0		
Kidney disease	2	1.0		
Cholesterol	9	4.5		
Hypothyroidism	7	3.5		
Blood pressure	10	5.0		
Stomach Diseases	11	5.5		
Psychiatric Illness Status				
Yes. I'm	18	9.0		
No	182	91		
Medication Use				
Yes. I'm	61	30.5		
No	139	69.5		
Variable		n	%	$\bar{x}$ (Ss)
Smoking				
Yes, I'm		58	29.0	
No		142	71	

Alcohol Use			
Yes, I'm	39	19.5	
No	161	80.5	
Diet for the last 1 year			
I never did	104	52.0	
I did it 1-4 times	61	30.5	
I did it 5-10 times	10	5.0	
I did more than 10	9	4.5	
I do not constantly	15	7.5	
Missing	1	0.5	
Skipping Meal			
Yes, I'm	170	85.0	
No	30	15.0	
Frequently Skipped Meals			
Don't skip	30	15.0	
Breakfast	46	23.0	
Lunch	77	38.5	
Dinner	6	3.0	
Snacks	41	20.5	
Diagnosed Sleep Disorder			
Yes, I'm	14	7.0	
No	186	93.0	
Amount of Water Consumed During the Day			
2 cups and less	13	6.5	
3-5 glasses of water	54	27.0	
6-8 cups	49	24.5	
9-12 cups	52	26.0	
More than 12 glasses of water	32	16.0	
Frequency of Physical Activity			
I do not do regular physical activity.	81	40.5	
1-2 per week	72	36.0	
3-4 per week	29	14.5	
Everyday	18	9.0	

When *Table 4.2* is considered, it can be mentioned that height measurements are between 147 and 188 cm. Body weight is minimum 41 kg and a maximum of 132 kg,

ranging from 41 to 138. BMI measurements are between 16.0 and 43.1 kg / m². Waist-hip ratios vary between 0.6 and 1.47.

Table 4.2. Descriptive Statistics of Participants' Anthropometric Measurements

Anthropometric Measurements (n=200)	Min	Max	$\bar{x}$	Ss
Body weight (kg)	41.0	132.0	69.792	16.5508
Length of height (m)	1.47	1.88	1.663	.09182
Body Mass Index (kg / m ²)	16.016	43.102	25.119	4.902
Waist circumference (cm)	50	133	82.30	16.533
Hip circumference	60	130	96.18	10.518
Waist / Hip ratio	.60	1.478	.856	.144

When *Table 4.3* is considered, it can be seen that The Eating Attitude Scale (EAT) scores of participants were non-normally distributed, with skewness of 1.35 (SE = 0.17) and kurtosis of 2.65 (SE= 0.34)

The Intuitive Eating Scale scores of participants were normally distributed, with skewness of – 0.37 (SE = 0.17) and kurtosis of 0.096 (SE= 0.34)

The Eating for Physical Rather Than Emotional Reasons (EPR) scores of participants were normally distributed, with skewness of -0.313 (SE= 0.17) and kurtosis of -0.218 (SE= 0.34)

The Unconditional Permission to Eat (UPE) scores of participants were normally distributed, with skewness of 0.311 (SE = 0.17) and kurtosis of -0.42 (SE= 0.34)

Reliance onHunger and Satiety Cues (RHSC) scores of participants normally distributed, with skewness of -0.415 (SE = 0.17) and kurtosis of -0.177 (SE= 0.34)

The Body-Food Choice Congruence (BFCC) scores of participants were normally distributed, with skewness of -0.750 (SE = 0.17) and kurtosis of 0.705 (SE= 0.34)

Table 4.3. Descriptive Statistics of Participants' Eating Attitude Scale, Intuitive Eating Scale, and Subdivision Scores

Scales	Min	Max	$\bar{x}$	Ss	Distortion/ Sh	Pressure/ Sh
EAT	3.00	75.00	20.7400	12.33504	1.353 / .172	2.651/ .342
Intuitive Eating Scale	41.00	108.00	80.5400	12.02378	-.369/ .172	.096/ .342
EPR	8.00	40.00	28.0050	6.96618	-.313/ .172	-.218/ .342
UPE	7.00	30.00	18.7800	4.49361	.311/ .172	-.042/ .342
RHSC	8.00	30.00	22.5250	5.08020	-.415/ .172	-.177/ .342
BFCC	3.00	15.00	11.2300	2.64045	-.750/ .172	.705/ .342

When *Table 4.4* is considered, it can be seen that The Pearson product-moment correlation coefficients were computed among EAT, Intuitive Eating Scale, EPR, UPE, RHSC, BFCC scores for participants. Also, the results of the correlation analyses showed significant correlation of the EAT scores of participants with intuitive Eating Scale ($r = -.179$; $p < 0.05$), Eating for Physical rather than Emotional Reasons (EPR) ($r = .794$; $p < 0.01$). Unconditional Permission to Eat (UPE) ($r = .263$; $p < 0.01$), RHSC ($r = .810$; $p < 0.01$), BFCC ($r = .453$; $p < 0.01$). The Intuitive Eating Scale was significantly correlated with UPE ($r = -.183$; $p < 0.01$) and RHSC scored ($r = -.124$; $p < 0.01$). In addition, the results of the correlation analyses were significantly correlated with all the subscales of Intuitive Eating Scale scores and EAT ($p < 0.05$).

Table 4.4 Pearson Correlation Analysis of The Relationship of Scales with Each Other

Scale	1	2	3	4	5
1.EAT					
2.IES	-.179*				
3.EPR	-.066	.794**			
4.UPE	-.183**	.263**	-.101		
5. RHSC	-.124	.810**	.493**	-.008	
6. BFCC	-.093	.453**	.199**	-.223**	.476**

* $p < 0.05$; ** $p < 0.01$

When *Table 4.5* is considered, it can be seen that The Pearson product-moment correlation coefficients were computed among EAT, Intuitive Eating Scale, EPR, UPE, RHSC, BFCC scores for participants with age. The results of the correlation analyses showed significant correlation of the UPE scores of participants with age ($r = -.170$; $p < 0.05$)

Table 4.5. Pearson Correlation Analysis Findings on the Relationship between the Scales and the Age Variable

Scale	Value	EAT	IES	EPR	UPE	RHSC	BFCC
Age (n=198)	R	-.039	.020	.047	-.170*	.031	.016
	P	.589	.778	.515	.016	.667	.822

* $p < 0.05$ ** $p < 0.01$

Table 4.6 shows the mean and standard deviation of anthropometric features and balance. The findings from Pearson correlation coefficient indicated that there is a weak

negative relation between the body weight and RHSC($r=-.003$) and also EPR ($r=-.043$). There is a weak positive relationship between the body weight and EAT ($r=0.226$).

Pearson's correlation coefficient indicated that there was a weak negative relation between body height and BFCC ($r=-.010$) and RHSC ($r=-.034$). There is a weak positive relationship between the height and EAT ($r=.043$).

The findings from Pearson correlation coefficient indicated that there is a weak negative relation between the Body Mass Index and UPE ($r=-.184$). There is a weak positive relation between the Body Mass Index and EAT ($r=.213$) and RHSC($r=.006$) and also BFCC ($r=0.45$).

Pearson's correlation coefficient indicated that there is a weak negative relation between the Waist/hip ratio (cm) and UPE ($r=-.157$) and RHSC($r=-.033$). There is a weak positive relation between the Waist/hip ratio (cm) and BFCC ($r=.047$).

Table 4.6. Pearson Correlation Analysis Findings on The Relationship of Scales with Anthropometric Measurements

Anthropometric measurements (n=200)	EAT	IES	EPR	UPE	RHSC	BFCC
Body weight (kg)	.226**	-.066	-.043*	-.121	-.003*	.024
Body height(m)	.099	.043*	.051	.079	-.034*	-.010*
Body Mass Index (kg/m ²)	.213**	-.107	-.088	-.184**	.006*	.045*
Waist circumference (cm)	.138	-.098	-.058	-.178*	-.015*	.036
Hip circumference (cm)	.085	-.040*	-.028	-.091	.019	.008*
Waist/hip ratio (cm)	.116	-.092	-.051	-.157*	-.033*	.047*

* $p<0.05$ ** $p<0.01$

The *Table 4.7* show that there is no statistically significant difference was found between eating attitude scores according to gender ($p > 0.05$). There was also no statistically significant difference between intuitive eating scores according to gender ($p > 0.05$).

Table 4.7. Independent Groups T-Test Findings on Differentiation of Scales by Risk Variable

Scales	Gender	Avg	Ss	t	p
EAT	Woman	21.31	12.66	.985	.326
	Male	19.44	11.57		
IES	Woman	79.91	12.27	-1.113	.267
	Male	81.97	11.40		
EPR	Woman	27.67	7.18	-1.030	.304
	Male	28.77	6.45		
UPE	Woman	18.78	4.22	-.014	.989
	Male	18.79	5.09		
RHSC	Woman	22.30	5.14	-.936	.350
	Male	23.03	4.95		
BFCC	Woman	11.17	2.74	-.521	.603
	Male	11.38	2.41		

* $p < 0.05$ ** $p < 0.01$

As it can be seen in *Table 4.8*, a Kruskal-Wallis test showed that education level affects BFCC score, $H(3) = 10.251$, $p = 0.017$. The results indicate significant difference for high school level ($M = 119.36$) over primary school level ($M = 117.46$), and graduated level ($M = 101.74$).

A Kruskal-Wallis test showed that education level affects UPE score, $H(3) = 12.42$, $p = 0.01$. The results indicate significant difference for university level ($M = 108.62$) over graduated level ($M = 104.41$), and high school level ($M = 97.85$).

The results indicate non-significant difference between education level for EAT $H(3)= 6.724$, $p=0.081$. The results also indicate a non-significant difference between education level for IES $H(3)= 4.401$, $p=0.221$, for Eating for Physical Rather Emotional Reasons $H(3)= 0.811$, $p=0.847$, for RHSC $H(3)= 0.925$, $p=0.819$.

Table 4.8. Kruskal Wallis H Test For Differentiation of Scales by Education Status Variable

Scales	Education Status	SO	H	Sd	p	Difference
EAT	Primary	125.52	6.724	3	0.081	
	High	99.67				
	University	99.37				
	Graduate	84.06				
IES	Primary	78.56	4.401	3	0.221	
	High	107.94				
	University	101.18				
	Graduate	106.50				
EPR	Primary	92.02	0.811	3	0.847	
	High	104.41				
	University	100.06				
	Graduate	104.19				
UPE	Primary school	63.21	12.422**	3	0.006	1<3
	High	97.85				
	University	108.62				
	Graduate	104.41				
RHSC	Primary	90.38	0.925	3	0.819	
	High	103.81				
	University	101.04				
	Graduate	102.54				
BFCC	Primary	117.46	10.251*	3	0.017	2>3
	High	119.36				
	University	89.81				
	Graduate	101.74				

* $p<0.05$ ** $p<0.01$

As it can be seen in *Table 4.9*, a Kruskal-Wallis test showed that income affects IES score, $H(2)= 10.552$, $p=0.005$. The results indicate significant difference for high income ($M = 135.08$) over low income ($M = 76.37$), and average income ($M=99.05$).

A Kruskal-Wallis test showed that income affects EPR score, $H(2)= 8.303$, $p=0.016$. The results indicate significant difference for high income ($M = 127.45$) over average income ($M = 100.26$), and low income ($M=74.13$).

A Kruskal-Wallis test showed that income affects RHSCscore, $H(2)= 8.006$, $p=0.018$. The results indicate significant difference for high income ($M = 128.00$) over average income ($M = 99.93$), and low income ($M=76.37$).

A Kruskal-Wallis test showed that income affects BFCC score, $H(2)= 9.722$, $p=0.008$. The results indicate significant difference for high income ($M = 129.30$) over average income ($M = 100.25$), and low income ($M=72.34$).

The results indicate non-significant difference between income for EAT $H(2)= 1.963$, $p=0.375$. The results indicate non-significant difference between income for UPE $H(2)= 2.076$, $p=0.354$.

Table 4.9. Kruskal Wallis H Test Findings Regarding the Differentiation of Scales According to the Variable of Income Status

Scales	Income Status	SO	H	Sd	P	Difference
EAT	Low	112.05	1.963	2	0.375	
	Middle	100.89				
	High	86.35				
IES	Low	76.37	10.552**	2	0.005	1<3 2<3
	Middle	99.05				
	High	135.08				
EPR	Low	74.13	8.303*	2	0.016	1<3
	Middle	100.26				
	High	127.45				
UPE	Low	118.63	2.076	2	0.354	
	Middle	98.56				
	High	98.88				

Scales	Income Status	SO	H	Sd	p	Difference
RHSC	Low	76.37				
	Middle	99.93	8.006*	2	0.018	1<3
	High	128.00				
BFCC	Low	72.34				
	Middle	100.25	9.722**	2	0.008	1<3
	High	129.30				

* $p < 0.05$ ** $p < 0.01$

In Table 4.10, the comparison of the mean all scale scores according to medical disorders is given. Having a medical disorder does not show a statistically significant difference according to all scales with subscales except one ($p > 0.05$). A statistically significant difference was found between UPE scores According to Medical Disorders ($p = 0.000$; $p < 0.01$).

Table 4.10. Independent Groups T-Test Findings on Differentiation of Scales by Medical Disorders

Scales	Medical Disorder	Avg	Ss	t	P
EAT	Yes	22.7455	13.86204	1.420	.157
	No	19.9793	11.66576		
IES	Yes	78.9455	12.74307	-1.156	.249
	No	81.1448	11.72840		
EPR	Yes	28.7273	6.62893	.903	.368
	No	27.7310	7.09289		
UPE	Yes	16.9273	4.22451	-3.704**	.000
	No	19.4828	4.40502		
RHSC	Yes	22.1455	5.97035	-.585	.560
	No	22.6690	4.71413		

Scales	Medical Disorder	Avg	Ss	t	P
BFCC	Yes	11.1455	2.87014	-.278	.781
	No	11.2621	2.55772		

* $p < 0.05$ ** $p < 0.01$

In *Table 4.11*, the comparison of the mean all scale scores according to dieting status in the last 1 year is given. Dieting status show a statistically significant difference according to EAT ($p < 0.05$). The results indicate significant difference for participants who say, "I do it all the time" ($M = 127.96$) over I did it 5-10 times ($M = 127.40$), and "I do it 10 times" ($M = 113.50$).

Dieting status show a statistically significant difference according to BFCC ($p < 0.05$). The results indicate significant difference for participants who say, "I do it 10 times" ($M = 164.56$) over I did it 1-4 times ($M = 102.40$), and "I do it all the time" ($M = 114.81$).

In *Table 4.11*, the comparison of the mean all scale scores according to dieting status in the last 1 year is given. Dieting status does not show a statistically significant difference according to other scales with subscales ($p > 0.05$).

Table 4.11 Kruskal Wallis H Test Findings on Differentiation of Scales By Dietary Status Variable in Last 1 Year

Scales	State of Domination in the Last 1 Year	SO	H	Sd	p	Difference
EAT	I've never done it.	84.70	15.424**	4	0.004	There's no meaningful difference.
	I've done it 1-4 times	110.41				
	I've done it 5-10 times	127.40				
	I've done more than 10.	113.50				
	I do it all the time.	127.96				
IES	I've never done it.	105.29	8.755	4	0.068	
	I've done it 1-4 times	83.78				
	I've done it 5-10 times	94.70				
	I've done more than 10.	132.28				
	I do it all the time.	100.35				

Scales	State of Domination in the Last 1 Year	SO	H	Sd	p	Difference
EPR	I've never done it.	106.58				
	I've done it 1-4 times	81.83				
	I've done it 5-10 times	97.85	8.452	4	0.076	
	I've done more than 10.	108.83				
	I do it all the time.	113.04				
UPE	I've never done it.	104.19				
	I've done it 1-4 times	97.48				
	I've done it 5-10 times	108.50	5.341	4	0.254	
	I've done more than 10.	76.00				
	I do it all the time.	73.23				
RHSC	I've never done it.	98.63				
	I've done it 1-4 times	94.25				
	I've done it 5-10 times	92.30	6.963	4	0.138	
	I've done more than 10.	146.39				
	I do it all the time.	96.62				
BFCC	I've never done it.	89.87				
	I've done it 1-4 times	102.40				
	I've done it 5-10 times	93.70	16.308**	4	0.003	1<4
	I've done more than 10.	164.56				2<4
	I do it all the time.	114.81				

* $p < 0.05$ ** $p < 0.01$

In Table 4.12, the comparison of the mean all scale scores according to skipped meals is given. Skipped meal does not show a statistically significant difference according to EAT ($p < 0.05$).

Table 4.12. Independent Groups T-Test Findings Regarding the Variation of Scales According to the Variable of Meal Skipped Status

Scales	Meal Skipped Status	Avg	Ss	t	p
EAT	Yes	20.3059	12.46678	-1.186	.237
	No	23.2000	11.44522		
IES	Yes	80.3118	11.76608	-.638	.524
	No	81.8333	13.53688		
EPR	Yes	28.0176	6.92690	.061	.951
	No	27.9333	7.30580		
UPE	Yes	18.7824	4.43023	.018	.986
	No	18.7667	4.91783		
RHSC	Yes	22.4059	4.92367	-.692	.494
	No	23.2000	5.93877		
BFCC	Yes	11.1059	2.49745	-1.309	.199
	No	11.9333	3.30030		

* $p < 0.05$ ** $p < 0.01$

In *Table 4.13*, it can be seen that a Kruskal-Wallis test showed that the skipped meal type affects In Body-Food Choice Congruence score, $H(4) = 15.326$, $p = 0.004$. The results indicate significant difference for participants who skipped snack ($M = 117.72$) over the score of participants who skipped dinner ($M = 115.58$), and lunch ($M = 95.08$). There is no other significant difference between scales and sub-scales

Table 4.13. Kruskal Wallis H Test Findings on Differentiation of Scales By Frequently Skipped Meal Variable

Scales	Squeezed	SO	H	Sd	p	Difference
EAT	I don't skip	115.73	6.232	4	0.183	
	Breakfast	108.20				
	Lunchtime	90.66				
	Dinner	76.33				
	Snacks	102.73				
IES	I don't skip	105.57	1.137	4	0.888	
	Breakfast	103.24				
	Lunchtime	95.34				
	Dinner	96.08				
	Snacks	104.06				
EPR	I don't skip	97.67	0.298	4	0.990	
	Breakfast	99.64				
	Lunchtime	101.24				
	Dinner	92.75				
	Snacks	103.28				
UPE	I don't skip	101.68	7.908	4	0.095	
	Breakfast	119.26				
	Lunchtime	89.62				
	Dinner	110.50				
	Snacks	97.55				
RHSC	I don't skip	106.08	0.732	4	0.947	
	Breakfast	101.50				
	Lunchtime	98.16				
	Dinner	87.92				
	Snacks	101.54				
BFCC	I don't skip	121.02	15.326**	4	0.004	1>2 2<5
	Breakfast	78.88				
	Lunchtime	95.08				
	Dinner	115.58				
	Snacks	117.72				

* $p < 0.05$ ** $p < 0.01$

In Table 4.14, it can be seen that a Kruskal-Wallis test showed that amount of water consumed daily affects In UPE score, $H(4) = 17.217$, $p = 0.002$. The results indicatesignificant difference for participants who say "3-5 cups" ($M = 120.14$) over the scoreofparticipants who say "6-8 cups " ($M = 101.88$), and "I do 9-12 a week" ($M = 86.28$).

A Kruskal-Wallis test showed that amount of water consumed daily affects in BodyFood Choice Congruence score, $H(4) = 20.432$, $p = 0.000$. The results indicate significantdifference for participants who say "more than 12 cups" ($M = 128.70$) over the

score of Participants who say "I do 9-12 a week" (111.14), and "6-8 cups" (M= 100.64). There is no other significant difference between scales and sub-scales

Table 4.14. Kruskal Wallis H Test Findings on Differentiation of Scales By Daily Amount of Water Consumed

Scales	Daily Water Consumed	SO	H	Sd	P	Difference
EAT	2 cups of water and less	99.15	1.225	4	0.874	
	3-5 cups	99.76				
	6-8 cups	93.74				
	9-12 cups	105.42				
	More than 12 cups	104.64				
IES	2 cups of water and less	105.35	2.546	4	0.636	
	3-5 cups	90.57				
	6-8 cups	106.99				
	9-12 cups	100.35				
	More than 12	105.59				
EPR	2 cups of water and less	110.35	4.051	4	0.399	
	3-5 cups	89.09				
	6-8 cups	100.55				
	9-12 cups	102.05				
	More than 12	113.16				
UPE	2 cups of water and less	126.92	17.217**	4	0.002	2>5 2>4
	3-5 cups	120.14				
	6-8 cups	101.88				
	9-12 cups	86.28				
	More than 12	77.63				
RHSC	2 cups of water and less	91.85	4.758	4	0.313	
	3-5 cups	87.87				
	6-8 cups	110.01				
	9-12 cups	102.95				
	More than 12	106.78				
BFCC	2 cups of water and less	64.46	20.432**	4	0.000	1<5 2<5
	3-5 cups	82.08				
	6-8 cups	100.64				
	9-12 cups	111.14				
	More than 12	128.70				

* $p < 0.05$ ** $p < 0.01$

In Table 4.15, it can be seen that a Kruskal-Wallis test showed that physical activity frequency affects In UnconditionalPermission to Eat score, $H(3)= 25.278$, $p=0.000$. The results indicate significant difference for participants who say "I do not do regular physical activity" ($M = 116.06$) over the score of participants who say "I do 1-2 a week" ($M = 76.37$), and "I do 3-4 a week" ($M= 74.38$).

A Kruskal-Wallis test showed that physical activity frequency affects Eat Body-FoodChoice Congruence score, $H(3)= 10.372$, $p=0.016$. The results indicate no significant difference.

Table15. Kruskal Wallis H Test Findings on Differentiation of Scales By Physical Activity Frequency Variable

Scales	Physical Activity	SO	H	Sd	p	Difference
EAT	I don't do regular physical activity.	90.29	4.668	3	0.198	
	I do 1-2 a week	103.57				
	I do 3-4 a week	108.29				
	I do it every day.	117.00				
IES	I don't do regular physical activity.	99.60	1.691	3	0.639	
	I do 1-2 a week	104.51				
	I do 3-4 a week	99.03				
	I do it every day.	84.47				
EPR	I don't do regular physical activity.	100.19	0.632	3	0.889	
	I do 1-2 a week	96.72				
	I do 3-4 a week	106.60				
	I do it every day.	101.74				
UPE	I don't do regular physical activity.	116.06	25.278**	3	0.000	2>4 1>4 1>3
	I do 1-2 a week	104.01				
	I do 3-4 a week	74.38				
	I do it every day	50.21				

Scales	Physical Activity	SO	H	Sd	p	Difference
RHSC	I don't do regular physical activity.	93.60				
	I do 1-2 a week	107.03	2.240	3	0.524	
	I do 3-4 a week	98.05				
	I do it every day.	104.03				
BFCC	I don't do regular physical activity.	85.59				
	I do 1-2 a week	106.40	10.372*	3	0.016	There's no meaningful difference.
	I do 3-4 a week	109.34				
	I do it every day.	125.62				
						<i>*p<0.05 **p<0.01</i>

5. DISCUSSION

This study aims to compare the relationships of intuitive eating and eating attitude with their socio-demographic characteristics in dieters and non- dieters, and 189 female and demographic form specially prepared for this study was used along with the IES and the eating attitude scale / test. Accordingly, while 104 people stated that they did not diet for the past 1 year, it was stated that the most skipped meal was lunch.

When the results obtained were examined, it was seen that the age of the persons do not have a significant relationship with the general intuitive eating and eating attitude. Likewise, no significant relationship was found between gender and all dependent variables. In a study conducted by Augustus-Horvath & Tylka (68) on women aged 18-25 and by Hawks among students (66), no evidence could be found when examining the literature that intuitive eaters had significantly lower BMI than those who did not eat intuitively. It has been stated that the evidence from clinical studies on the cause-effect relationship between inclusion an intuitive eating program and weight loss is insufficient. Two of the eight studies on weight loss were found to have insufficient sample size (69), lack of a control group (38), and limited follow-up time. In addition, it has been reported that the completion of an intuitive eating program results in weight loss (70). In this study, it was stated that the eating attitude scale was related to a significant positive relationship with BMI and body weight.

Other studies discussing the relationship between BMI and intuitive eating indicate that there is a negative relationship between BMI and intuitive eating (71. 72). Among the first reasons for the negative relationship between BMI and intuitive eating, it can be stated that the idea of diet is not accepted and food is allowed unconditionally. As mentioned earlier, diets are powerful predictors of weight gain (73). It is stated that the restrictive eating attitude that does not allow food, similarly, causes weight gain (74, 75). The intuitive eating model, which concentrates more on the restricted and separates persons from the feelings of hunger and satiety, has more positive effects on people in terms of weight management than eating without consciousness.

All studies with a follow-up of more than eighteen months also found that persons involved in intuitive eating programs maintained their weight (76, 77). However, no statistically significant change in BMI could be detected between the groups during the two-year follow-up phase performed by Bacon et al. A randomized controlled trial was carried out to address the impact of the health model on all aspects of health improvement. It was seen in the study that the understanding of health in all aspects promotes homeostatic regulation and intuitive eating. The people included in the study were divided into two groups: diet group and health group in all aspects. Anthropometric measurements (weight, body mass index), physiological patterns (blood lipids, blood pressure), energy expenditure, eating movements (limiting, eating problem pathology) and psychological states (personality esteem, depression, body image) of these two groups were also discussed. In consequence of the study, it was stated that this model built up a behavioral difference in those involved in the long period, while diet did not (76). The negative relationship between unconditional consent to eat and BMI is also supportive in this study. Furthermore, considering the maximum values, BMI average ($\bar{x}$ = 25,12) and intuitive eating average ($\bar{x}$ = 80,54) values are quite high.

In another study by Denny et al. (78), including men and women with age ranges of 25, BMI values and intuitive eating scores of individuals were compared. It has been found that people with normal weight and underweight have higher intuitive eating scores than people with overweight and obesity. They stated that people who exhibit intuitive eating behavior have confidence in telling their bodies how much food they should consume, and that they are less likely to have an eating behavior problem than those who do not. In a study conducted with men and women between the ages of 21-32, in which health behavior was discussed in five dimensions, it was determined that paying attention to the recommendations related to health and consciousness increased with the increase in age, income and education level (79).

Recently, the number of studies on intuitive eating has increased. Current studies emphasize that there is a negative relationship between intuitive eating and BMI and that it has more positive effects on individuals in terms of mental health, but it is also necessary to support these data with more studies. It is stated that Denny et al. (46) can

be useful in providing weight control and preventing eating disorders through intuitive eating. Thus, it was stated that as a result of intuitive eating, irregular eating movements can be reduced and weight loss can be achieved in a healthier way.

A cross-sectional study discussed the relationship between intuitive eating and BMI, using the hypothesis that persons with intuitive eating behavior will have a lower BMI, and also addressed whether the low BMI of intuitive eaters could be explained by their food preferences. A nationally representative sampling format of the sample population was obtained from the New Zealand electoral register and the participation criteria were: female gender, age range 40-50 years; non-pregnant and non-breastfeeding. A total of 2,500 participants who met these inclusion criteria were randomly selected for inclusion in the study. After adjusting for the variables, the results revealed an inverse link between BMI and IES scores, implying that lower BMIs had more positive intuitive eating behavior. Notably, for every 10-point increase in total IES scores, a 6.5% decrease in BMI was identified. It has been stated that more advanced research is needed to clearly understand the relationship between intuitive eating and BMI but that intuitive eating may be a “promising model for weight management and prevention of weight gain” (80); and it is clear that more work is needed in this context.

In this study, despite the majority of women, it was not determined that gender caused a significant change. In a study of gender-based dietary restriction and variation in weight, it was found that diet restriction was positively associated with weight gain in women and negatively associated with men (81). Likewise, in a study by Klesges et al. it was concluded that dietary restriction was associated with weight gain in women but not in men (82). It has been determined that tendency of men was more intuitive eating, less dieting, more satisfaction with food and less interest in fashion. On the other hand, it has been observed that women pay more attention to losing weight, calculating their weight, and focusing on healthy food choices. For both men and women, intuitive eating was associated with greater pleasure in food preference and consumption, lower health considerations in food preferences, lower BMI, breakfast (indirect relevance), and variety in food. Significant relevance has been found between intuitive eating and other measures of diet quality in terms of junk food intake levels (83).

In another study, as a result of the study of Dyck Z et al. (84) that included 1134 participants, 81.3% of whom were women over the age of 18, it was determined that

women with eating disorders had significantly lower overall intuitive eating subscale scores and total scores than women without an eating disorder diagnosis. From this point of view, it is possible to say that there are different results regarding gender and eating attitudes and intuitive eating relationships. In addition, in the literature, the factors that can cause eating disorders in the form of intuitive eating and eating without thinking, and studies conducted in the adolescent group are more common.

As another variable, considering the education, significant differentiation was observed in the sub-dimensions of unconditional consent to eat and harmony of body-food choice. While the unconditional consent score is highest in university graduates, it is the lowest in body-food selection compatibility. It is noteworthy that in the literature, the importance of education for eating attitudes is emphasized rather than formal education. Current data shows that intuitive eating has many benefits. First, it was stated that intuitive eating training has a long-term lasting effect on restoring physiological and psychological state over conventional weight loss aid (85,77). Secondly, this approach has a wholistic expansion in terms of activity. By approving many adaptation techniques (for example, by increasing interoceptive sensitivity), it reduces the risk of malnutrition and also improves physiological and psychological outcomes, preventing the onset of chronic diet-related disorders (eg, obesity) (2).

In a cross-sectional study conducted by Jacobs et al., the effect of one-hour eating awareness training on awareness and food intake was evaluated. After the training, those included in the study reported an increase in their eating awareness scale scores, with more than 85% of them making healthier food choices at lunchtime. In conclusion, it reveals that eating awareness education can affect food intake and therefore improve healthy weight planning (87). Studies state that eating awareness practices can reduce the state of eating and emotional eating in response to environmental factors. In this direction, it would not be wrong to say that education about eating provides benefits on BMI and healthy nutrition.

Another important finding is dietary status. Examining the dieting status in the last 1 year, the eating attitude scale is remarkably related. The highest score is for those who diet constantly, followed by dieters 5-10 times. On the other hand, the sub-dimension of accordance of body-food choice is significantly higher in the group that has been on more than 10 diets in the last 1 year; however, there is no association with dietary status

in other dimensions. Whereas, in one study, Gagnon-Girouard et al. (77) found a small but significant weight loss among those included in a non-diet model. The total working time continued for 16 months, with a four-month support phase and a 12-month follow-up phase. At the end of the study, no significant weight loss was noted in the social support group and control group, while a small but significant decrease was found in the weight of the team in the non-diet model (77). Therefore, examining from this point of view, it would not be wrong to say that dieting is significantly related as expected.

Again, examining for the variable of skipping meals, which is another hypothesis, it was found that there was no significant relationship. In a study conducted by Smith and Hawks, searching the relevant sources in the literature, it was determined that intuitive eating was related to low BMI, diet patterns, low food anxiety, diet habits, and breakfast in men and women (83). In the thesis study conducted by Baş (88), the prevalence of orthorexia in dietitians and its effect on health parameters were discussed. The results revealed the prevalence of orthorexia as 64% (36 women) in the sample (N = 75, 59 women). Considering the demographic parameters, no statistically significant change could be detected related to age, gender, BMI, marital status, chronic diseases, physiological activities, alcohol and cigarette use, vitamin intake and water consumption. Evaluating the daily consumed food ratios, no statistically significant change in terms of energy, protein, fat, cholesterol, carbohydrate, fiber, vitamin A, vitamin B1, vitamin B2, vitamin B6, iron, calcium, magnesium, phosphorus and zinc could be detected among dietitians with and without orthorexia. In the study, only the level of vitamin E supplementation was higher in dieters with orthorexia. In this study, it was determined that there was only a significant relationship between the accordance of body-food choice and the skipped meal, and it was seen that those who skipped the meal had the highest average. This group was followed by those skipping dinner. Özkan (42) stated in his research that 45.6% of men and 66.5% of women skip meals, and the difference between genders is important ($p=0,003$). 35.9% of persons skip lunch. The most frequently skipped meal was lunch (53.1%), while in women it was determined as snacks (36.4%). Among the reasons for skipping meals, persons mostly stated "not finding time" (Men: 47.1%; Women: 43.8%).

Güzey (89) stated in his research that 62% of people skip meals. While 80.6% of people who skip meals skip the night meal, 64.5% skip the mid-morning refreshment. Persons who skip breakfast constitute 12.9% of people who skip meals, while those who skip lunch constitute 29%. No one skips the dinner. Among the total number of meals skipped, the night snack constitutes 32.5% of the most skipped meals. The first reason for people who skip meals is stated as “not wanting” (53.1%) and the second reason being “not finding time” (18.8%). The existence of different results reveals the necessity of saying that more studies are needed.

Examining another variable for physical activity, it is seen that the group that does not engage in regular activity has the highest score in unconditional consent to eat. As the frequency of activity increases, the score decreases significantly. Although the difference between the groups is not significant, the harmony of body food choice and activity frequency are highly negatively related. Examining similar studies in the literature, Avalos and Tylka (81) found that people with intuitive eating behavior do not care much about their physical appearance and praise their bodies more, thus exalting their bodies by directing them to healthy movements in the form of physical activities. Yaşar (90) determined that there is a significant relationship between the level of physical activity and the total score of intuitive eating in university students. In another study, in which the scale developed by Hawks et al. (66) was used to detect people who eat intuitively, and the sample consisted of men, the relationship between the level of physical activity and the total score of intuitive eating was discussed, and it was stated that as the level of physical activity in men increased, the total score of intuitive eating also increased (91).

A total of 400 women and men aged 40 and over were included in another study, and it was determined in the study (92) that emotional eating behavior increased with higher physical activity level. In a study conducted by Johnson et al., a positive correlation was determined between the level of physical activity and healthy food preference in men. In the same study, a positive correlation was found between more physical activity and the intake of healthy foods and less fatty foods for women (93).

Intuitive eating is associated with less use of unhealthy weight control movements and irregular eating (skipping meals, taking diet pills, fasting, vomiting, and overeating). However, the reduction in weight cycling is thought to be related to physical health benefits such as lower blood pressure and cholesterol levels.

Some studies carried out have found that intuitive eating is more successful in short-term weight loss than a calorie-restricting diet. This is not unexpected. Intuitive eating is not intended to lose weight or produce short-term measurable results, but rather has a wide-ranging and long-term supportive nature.



6. CONCLUSION

1. The height measurements are between 147 and 188 cm. Body weight is minimum 41 kg and a maximum of 132 kg, ranging from 41 to 138. BMI measurements are between 16.0 and 43.1 kg / m². Waist-hip ratios vary between 0.6 and 1.47.

2. There is a significant correlation between Emotional Eating scores with intuitive Eating Scale with all its subscales.

3. there is a weak negative relation between the body weight and RHSC, BFCC and EPR. Also there is a weak negative relation between the Body Mass Index and UPE.

There is a weak positive relation between the Body Mass Index and EAT and RHSC and BFCC. Also, there is a weak positive relationship between the body weight, height and EAT.

4. Participants who graduated from high school shows significantly higher BFCC scores than who graduated from primary school and university.

Participants who graduated from high school shows significantly lower UPE scores than who graduated from university and master.

5. Participants who have medical disorder show higher UPE scores than others.

6. Dieting status show a statistically significant difference according to BFCC. Participants who say, "I do it 10 times" Show higher BFCC scores than others.

7. Participants who skipped snack show higher BFCC scores than others.

8. Participants who drink 3-5 cups water have higher scores than others. Participants who drink 12 cup and more cups water have higher BFCC scores than others.

9. Participants who do not do regular physical activity show higher BFCC scores than others.

7. RECOMMENDATIONS

In this research, studying with intuitive eating and eating attitudes was conducted only among adult individuals aged 25-55. Child/adolescent individuals may be included in future studies. In this context, more cross-sectional-descriptive studies can be conducted to strengthen the causal relationship between intuitive eating behavior, eating attitude, diet and anthropometric measurements.

Services and policies including holistic approaches such as psycho-diet, which includes intuitive eating behavior and eating attitude practices, can be developed across our country, both to reduce overweight/obesity and to maintain weight lost.

In this study, no effect of gender on dependent variables was observed. For this reason, it is recommended to obtain comparable data by studying different sample groups in future studies.

It has been observed that the relationships between intuitive eating and eating attitudes have not been compared in Turkey, it is limited to the literature research. In this context, based on the meaningful results we obtained in our study, it can be concluded that it will contribute to the literature to a certain extent and will have an original quality.

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9. APPENDIXS

9.1. Ethical Committee Declaration

Sayı:
Konu: Klinik araştırma için
izinhk.

27/03/ 2020

Yeditepe Üniversitesi Klinik Araştırmalar Etik Kurul Başkanlığına

Yeditepe Üniversitesi Sağlık Bilimleri Enstitüsü Beslenme ve Diyetetik Bölümü programında akademik amaçlı olarak yapılması planlanan “Düzenli Beslenme Danışmanlığı Alan ve Almayan Kişilerde Sezgisel Yeme ve Yeme Tutumu İlişkilerinin Karşılaştırılması” isimli klinik araştırmanın Yardımcı Araştırmacı; Dyt. Tansu Nur Çalım tarafından gerçekleştirilmesi uygundur.

Gereğini bilgilerinize sunarım.

Hastane Baştabibi / Kurum Amiri

Dr. Kenan KIR
Sağlık Bakanlığı

9.2. Institution Permit Letter

Sayı:
Konu: Klinik araştırma için
izinhk.

27/03/ 2020

Yeditepe Üniversitesi Klinik Araştırmalar Etik Kurul Başkanlığına

Yeditepe Üniversitesi Sağlık Bilimleri Enstitüsü Beslenme ve Diyetetik Bölümü programında akademik amaçlı olarak yapılması planlanan “Düzenli Beslenme Danışmanlığı Alan ve Almayan Kişilerde Sezgisel Yeme ve Yeme Tutumu İlişkilerinin Karşılaştırılması” isimli klinik araştırmanın Yardımcı Araştırmacı; Dyt. Tansu Nur Çalım tarafından gerçekleştirilmesi uygundur.

Gereğini bilgilerinize sunarım.

Hastane Baştabibi / Kurum Amiri

Dr. Kenan KIR
Sağlık Bakanlığı

9.3. Informed Consent Form for Research Purposes

	KLİNİK ARAŞTIRMALAR ETİK KURULU BİLGİLENDİRİLMİŞ GÖNÜLLÜ OLUR FORMU	TARİH: 27.03.2020 VERSİYON: 1
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Araştırma Konusu: Düzenli beslenme danışmanlığı alan ve almayan kişilerde sezgisel yeme ve yeme tutumu ilişkilerinin karşılaştırılması Araştırmacı: Tansu Nur Çalim Çalışmaya katılım gönüllülük esasına dayalıdır. Aşağıdaki bilgileri okuyup anladıktan sonra araştırmaya katılmak isterseniz formu imzalayınız. Bu araştırma, T.C. Yeditepe Üniversitesi Beslenme ve Diyetetik Yüksek Lisans Programı tezi kapsamında Dr. Öğr. Üyesi, Hülya DEMİR danışmanlığında gerçekleştirilmektedir. Yeme tutumu ve sezgisel yeme ilişkisine dair bilgi kazanmak adına çalışmaya katılmanız önerilmektedir. Eğer araştırmaya katılmayı kabul ederseniz size, Diyetisyen Tansu Nur Çalim tarafından birkaç farklı soru formunda oluşan anketler verilecektir. Çalışmanın ortalama 20 dakika sürmesi öngörülmektedir. Toplamda 200 gönüllü katılımcı yer alacaktır. Çalışmaya kendi rızamla gönüllü olarak katılmayı kabul ediyorum.

ARAŞTIRMAYA KATILMAYI KABUL EDEN KİŞİNİN; TARİH: İMZASI:
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9.4. Sosyo-Demografic Form

Yaşınız: _____

Medeni durumunuz: Bekâr ☐ Dul ☐ Evli ☐ Boşanmış ☐

Eğitim durumunuz: İlkokul ☐ Lise ☐ Üniversite ☐ Yüksek lisans ☐

Annenizin eğitim durumu: Okur-yazar ☐ İlkokul ☐ Lise ☐ Üniversite ☐ Yüksek lisans ☐

Babanızın eğitim durumu: Okur-yazar ☐ İlkokul ☐ Lise ☐ Üniversite ☐ Yüksek lisans ☐

Halen bir işte çalışıyor musunuz? ☐ Çalışıyorum ☐ Çalışmıyorum ☐ Emekliyim

Gelir düzeyinizi nasıl değerlendiriyorsunuz? ☐ Düşük ☐ Orta ☐ Yüksek

Geçirdiğiniz tıbbi bir rahatsızlık var mı? ☐ Evet ☐ Hayır

Evet ise :

1. Diyabet ☐ 2.Kanser ☐ 3.Kardiyovasküler hastalıklar ☐ 4. Böbrek Hastalığı ☐

5. Kolesterol ☐ 6. Hipotroid ☐ 7. Tansiyon ☐ 8.Mide Hastalıkları ☐

Psikiyatrik bir rahatsızlığınız var mı ? ☐ Evet ☐ Hayır

Düzenli bir ilaç kullanımı mevcut mu ?

☐ Evet ☐ Hayır

Sigara kullanıyor musunuz ?

☐ Evet ☐ Hayır

Alkol kullanıyor musunuz?

☐ Evet ☐ Hayır

Son 1 yıldır düzenli diyet yaptınız mı?

☐ Hiç yapmadım ☐ 1-4 kez yaptım
☐ 5-10 kez yaptım ☐ 10'dan fazla yaptım ☐ Sürekli yaparım

Atladığınız öğün olur mu?

☐ Evet ☐ Hayır

Hangi öğünleri sık atlarsınız? (Birden fazla seçim yapabilirsiniz)

☐ Atlamam

☐ Kahvaltı

- ☐ Öğle yemeđi
- ☐ Akşam Yemeđi
- ☐ Ara öğünler

Tanısı olan uyku bozukluđunuz mevcut mu?

- ☐ Evet
- ☐ Hayır

Bir gün içerisindeki su tüketim miktarınız nedir?

- ☐ 2 su bardađı ve daha az
- ☐ 3-5 su bardađı
- ☐ 6-8 su bardađı
- ☐ 9-12 su bardađı
- ☐ 12'den fazla su bardađı

Fiziksel Aktivite sıklıđınız nasıldır?

- ☐ Düzenli fiziksel aktivite yapmam.
- ☐ Haftada 1-2 yaparım
- ☐ Haftada 3-4 yaparım
- ☐ Her gün yaparım.

ANTROPOMETRİK ÖLÇÜMLER

Vücut ağırlıđı (kg) :

Boy uzunluđu (cm) :

Beden Kütle İndeksi (kg/m²) :

Bel çevresi (cm) :

Kalça çevresi (cm):

Bel/Kalça oranı:

9.5. Intuitive Eating Scale

SEZGİSEL YEME ÖLÇEĞİ

Bu anket sizin yeme alışkanlıklarınızı ve sezgisel yemeniz ile ilgilidir. Lütfen her bir soruyu dikkatlice okuyunuz ve size uygun gelen seçeneği kutunun içine yazınız.

Kesinlikle Katılmıyorum (1)	Katılmıyorum (2)	Kararsızım (3)	Katılıyorum (4)	Kesinlikle Katılıyorum (5)
1. Yüksek yağ, karbonhidrat veya kalori içeren yiyeceklerden kaçınmaya çalışırım.				()
2. Kendime yeme izni vermediğim yasaklı yiyecekler vardır.				()
3. Sağlıksız bir şey yediğimde kendime çok kızarım.				()
4. Bir yiyeceği çok istiyorsam, kendime onu yeme izni veririm.				()
5. Herhangi bir anda, arzuladığım bir yiyeceği kendime yeme izni veririm.				()
6. Neyi, ne zaman ve/veya ne kadar yiyeceğimi belirleyen yeme kurallarını veya diyet planlarını takip ETMEM.				()
7. Duygusal hissettiğimde (ör. kaygılı, depresif, üzgün), fiziksel olarak aç olmasam bile kendimi yemek yerken bulurum.				()
8. Yalnız hissederken, fiziksel olarak aç olmasam bile kendimi yemek yerken bulurum.()				()
9. Yiyecekleri olumsuz duygularımı yatıştırmak için kullanırım.				()
10. Stresliyken, fiziksel olarak aç olmasam bile kendimi yemek yerken bulurum.				()
11. Beni rahatlatması için yiyeceklere başvurmama gerek kalmadan olumsuz duygularımla (ör. endişe, üzümlük) baş edebilirim.				()
12. Sıkılmışken, sırf yapacak bir şey olsun diye yemek YEMEM.				()
13. Yalnız hissederken, beni rahatlatması için yemek yemeye BAŞVURMAM.				()
14. Stres ve kaygıyla baş etmede, yemek yemekten başka yollar bulurum.				()
15. Ne zaman yemek yemem gerektiğini söylemesi konusunda vücuduma güvenirim.				()
16. Ne yemem gerektiğini söylemesi konusunda vücuduma güvenirim.				()
17. Ne kadar yemek yemem gerektiğini söylemesi konusunda vücuduma güvenirim.				()
18. Ne zaman yemek yiyeceğimi söylemesi konusunda açlık sinyallerime güvenirim.				()
19. Ne zaman yemeyi bırakmamı söylemesi konusunda tokluk sinyallerime güvenirim.()				()
20. Ne zaman yemeyi bırakmamı söylemesi konusunda vücuduma güvenirim.				()
21. Çoğu zaman besleyici yiyecekler yemeyi arzularım.				()
22. Çoğu zaman vücudumun verimli (iyi) bir şekilde işlemlerini sağlayacak yiyecekler yerim.				()
23. Çoğu zaman bana enerji ve dayanıklılık veren yiyecekler yerim.				()

9.6. The Eating Attitude Scale

YEME TUTUM TESTİ (YTT40)

Her soru için uygun gördüğünüz seçeneği kutunun içine yazınız.

SORULAR	Daima(1)	Çok(2)	Sık(3)	Bazen(4)	Nadiren(5)	Hiçbir(6)
	sık	sık				zaman
1. Başkaları ile birlikte yemek yemekten hoşlanırım.						()
2. Başkaları için yemek pişiririm, fakat pişirdiğim yemeği yemem.						()
3. Yemekten önce sıkıntılı olurum.						()
4. Şişmanlamaktan ödüm kopar.						()
5. Acıktığımda yemek yememeye çalışırım.						()
6. Aklım fikrim yemektedir.						()
7. Yemek yemeyi durduramadığım zamanlar oldu.						()
8. Yiyeceğimi küçük küçük parçalara bölerim.						()
9. Yediğim yiyeceğin kalorisini bilirim.						()
10. Ekmek, patates, pirinç gibi yüksek kalorili yiyeceklerden kaçınırım.						()
11. Yemeklerden sonra şişkinlik hissedirim.						()
12. Ailem fazla yememi bekler.						()
13. Yemek yedikten sonra kusarım.						()
14. Yemek yedikten sonra aşırı suçluluk duyarım.						()
15. Tek düşüncem daha zayıf olmaktır.						()
16. Aldığım kalorileri yakmak için yorulana kadar egzersiz yaparım.						()
17. Günde birkaç kere tartılırım.						()
18. Vücudumu saran dar elbiselerden hoşlanırım.						()
19. Et yemekten hoşlanırım.						()
20. Sabahları erken uyanırım.						()
21. Günlerce aynı yemeği yerim.						()
22. Egzersiz yaptığımda harcadığım kalorileri hesaplarım.						()
23. Adetlerim düzenlidir. (Yalnızca kızlar cevaplandırarak)						()
24. Başkaları çok zayıf olduğumu düşünür.						()
25.Şişmanlayacağım (vücudumun yağ toplayacağı) düşüncesi zihnimi meşgul eder.						()
26. Yemeklerimi yemek, başkalarınınkinden daha uzun sürer.						()
27. Lokantada yemek yemeyi severim.						()
28. Müshil kullanırım						()
29. Şekerli yiyeceklerden kaçınırım.						()
30. Diyet (perhiz) yemekleri yerim.						()
31. Yaşamımı yiyeceğin kontrol ettiğini düşünürüm.						()
32. Yiyecek konusunda kendimi denetleyebilirim.						()
33. Yemek konusunda başkalarının bana baskı yaptığını düşünürüm.						()
34. Yiyeceklerle ilgili düşünceler çok zamanımı alır.						()
35. Kabızlıktan yakınırım.						()
36. Tatlı yedikten sonra rahatsız olurum.						()
37. Diyet (perhiz) yaparım.						()
38. Midemin boş olmasından hoşlanırım.						()
39. Şekerli, yağlı yiyecekleri denemekten hoşlanırım.						()
40. Yemeklerden sonra içimden kusmak gelir.						()