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Evaluation of the relationship between nutritional habits, use of nutritional supplements and intuitive eating of healthcare professionals during the COVID-19 pandemic

Nazan Erenoglu Son

Anadolu University, Faculty of Health Sciences, Department of Nutrition and Dietetics. Eskişehir, Türkiye

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Abstract

The aim of this study was to evaluate the relationship between the nutritional habits, use of nutritional supplements and intuitive eating of healthcare professionals between the ages of 18 and 65 living in Türkiye during the COVID-19 pandemic. This study was conducted with a total of 252 participants (208 female, 44 male) between February 1 and May 1, 2021. Data were obtained from an online questionnaire form, which included a questionnaire consisting of questions about the socio-demographic characteristics of the participants, their nutritional habits, anthropometric measurements and nutritional supplements and the Intuitive Eating Scale-2 (IES). While the mean IES score of the participants was 3.35±0.44, it was 3.46±0.39 for males and 3.33±0.44 for females. The mean scores of participants from Unconditional Permission to Eat, Eating For Physical Rather Than Emotional Reasons, Reliance on Hunger and Satiety Cues and Body-Food Choice Congruence sub-dimensions of the scale were 3.16±0.67, 3.21±0.82, 3.58±0.79 and 3.59±0.70, respectively. A total of 27.8% of the participants were found to use nutritional supplements. There was no statistically significant relationship between the total score of IES and the sub-dimension mean scores and the status of the use of nutritional supplements. As a result of the study, a negative statistically significant relationship was found between the Body Mass Index values of the participants and the IES ($p<0.001$). In other words, as the BMI value increases, intuitive eating levels decrease. Improving the level of intuitive eating would be a helpful factor in controlling body weight.

Keywords: COVID-19, healthcare professionals, nutritional supplement, intuitive eating

Introduction

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely disease and infirmity" [1]. While the public's interest in health and nutrition is constantly increasing, non-communicable diseases related to nutrition such as obesity, type 2 diabetes mellitus, hypertension, coronary heart disease and metabolic syndrome are observed to increase widely due to inadequate and unbalanced nutrition [2].

Most of the studies on eating behaviour have traditionally focused on describing and explaining pathological eating patterns without taking adaptive eating patterns into account. Recently, pathological eating patterns have been argued not to represent only physical capacity. New trends are drawing attention to adaptive eating patterns. Intuitive eating has been introduced as an adaptive eating style and has especially attracted the attention of experts who are conducting clinical studies [3].

Intuitive Eating is defined as "the dynamic process involving the harmony of mind, body and food". It refers to an adaptive eating style that relies mainly on cues of hunger and satiety to regulate food intake. It contains a strong connection with internal body signals known as internal perceptual awareness in individuals. The concept of the intuitive eating style was developed in 1995 by Tribole and Resch who conducted studies on this subject [4]. Intuitive eating has been proposed as an eating style that promotes a positive attitude and relationship towards nutrients,

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Corresponding Author: Nazan Erenoglu Son, Anadolu University, Faculty of Health Sciences, Department of Nutrition and Dietetics. Eskişehir, Türkiye
Email: neson@anadolu.edu.tr

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physical activity, and one's body without focusing on weight loss. However, weight and Body Mass Index (BMI) changes in different methods were taken into account in comparison studies. The results of these studies revealed the occurrence of positive changes in eating behaviours in response to the body's physiological cues with intuitive eating. These changes have been shown to lead to more weight loss [5]. Another study in which no weight loss was observed reported there was an improvement in both unbalanced eating behaviour and individuals' lipid profiles [6]. The most obvious positive relationship between intuitive eating and health has been shown to be the improvement in psychological health indicators [7]. For example, in their study, Polivy et al. conducted a "do not stop normal eating" program with a group of morbidly obese women. The program consisted of 10 sessions of two hours each, in which the principles of intuitive eating were taught and the health consequences for the individuals who eat healthily were explained. Results showed statistically significant improvements in depression, well-being, and self-esteem [8]. Furthermore, some researchers have suggested that intuitive eating might play a preventive role in the development of obesity [9]. Despite all this, there is limited data on the relationship between intuitive eating and food intake. Although there are many studies related to intuitive eating, we could not come across any study in the literature examining its relationship with nutritional supplement use or the effect of intuitive eating during the COVID-19 pandemic.

According to the results of few studies reported on this subject; a cross-sectional study conducted with middle-aged women in New Zealand showed a positive significant relationship between intuitive eating scores and vegetable intake [10]. In another cross-sectional study conducted with students, no relationship was observed between students' snack consumption and IES. However, there was a positive relationship between Intuitive Eating Scale-2 (IES) and the pleasure of eating, and a negative relationship was found between IES and health awareness [11].

With this study, we aimed to evaluate the nutritional habits, use of nutritional supplements and intuitive eating behaviours of healthcare professionals who showed great dedication during the COVID-19 pandemic.

Material and Methods

Location, time and sample selection of the study

This study was conducted between February 1, 2021, and May 1, 2021, with healthcare professionals living in Turkiye during the COVID-19 pandemic. A screening model from quantitative research methods was used in this study. The study sample was determined by using the purposive sampling method, one of the non-random sampling methods. The criterion sampling method, one of the objective sampling methods, was used in determining the sample [12]. The study were volunteers, aged between 18 and 65 who met the inclusion criteria.

The study data were collected from 252 volunteer healthcare professionals who were aged between 18 and 65 and living in Türkiye. Healthcare professionals who met the inclusion criteria and volunteered to participate in the study filled out the questionnaires online via Google Forms with the link sent through social media. The questionnaire consisted of four sections: Personal information, nutritional habits, use of nutritional supplements and intuitive eating scale. The BMI values of the participants were calculated by the researchers. The personal information section of the questionnaire was prepared by the researchers, taking previous studies into account.

The personal information section; consists of 12 questions including five on demographic characteristics (gender, age, marital status, educational status and occupation), four related to health information (chronic disease status, drug use status, smoking status and alcohol consumption status), one related to nutrition education, and two related to anthropometric measurements (height and body weight). BMI values were calculated as per the WHO's current guidelines. While WHO defines the normal BMI range as 18.5 to 24.9, a BMI≥25-29.9 kg/m^2 is classified as overweight, BMI≥30-39.9 kg/m^2 as obese and BMI≥40 kg/m^2 as morbid obesity [13].

Nutritional habits section; consists of 11 questions. In this section, there were questions on how many main meals the participants have, whether they regularly have breakfast every day, whether they skip the main meal and if skipped which meal they skip, the reason for skipping meals, the number of daily snacks, the type of food/beverages consumed most frequently between meals, the amount of daily water consumption, the amount of tea/coffee consumption per day, their preference for salt in their meals and their way of eating.

The use of nutritional supplements; consisted of three questions. This section had questions on whether the participants use nutritional supplements, the reason for using nutritional supplements (to maintain good health or treatment if there was a disease, the name of the disease) and which nutritional supplement they use.

Eating Style Scale; Intuitive Eating is defined as "the dynamic process involving the harmony of mind, body and food". It refers to an adaptive eating style that relies mainly on cues of hunger and satiety to regulate food intake. It was developed by Tribole and Resch in 1995 as an intuitive eating style scale. Four basic components of intuitive eating have been identified and supported experimentally by various studies [4]. The intuitive eating scale was developed and clustered into three areas by Tylka in 2006. It was revised again by Tylka and Kroon Van Diest (2013) and suggested that Intuitive Eating includes four key characteristics:

1. Unconditional Permission to Eat
2. Eating for Physical rather than Emotional Reasons
3. Reliance on Hunger and Satiety Cues
4. Body-Food Choice Congruence [14].

The validity and reliability studies for the Turkish adaptation of the scale were performed by Bas et al. [15]. The intuitive eating

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scale does not have a cutoff point and is used to measure intuitive eating. The items in the original scale are evaluated on a 5-point likert type. The items are scored between 1 and 5 based on the answer given (1=strongly disagree, 2=disagree, 3=neither agree nor disagree, 4=agree, 5=strongly agree). Items 1, 2, 3, 6, 7, 8 and 9 are reverse-scored on the scale. The higher the score obtained, the higher the level of intuitive eating.

Statistical evaluation of data

SPSS 22 statistical package program was used in the analysis of the data obtained in the study. The analysis of the data was carried out in two stages. In the first stage, assumption tests (normal distribution) were performed using descriptive statistics. Furthermore, descriptive data such as frequency, percentage, mean and standard deviation were used at this stage to provide information about the general characteristics of the sample. Data for continuous variables are presented as mean ± standard deviation, while data for discontinuous variables are as numbers (%). The chi-square, t-test for independent groups, one-way ANOVA and correlation analysis were used in the second stage. In all analyses, $p<0.05$ was accepted as the statistical significance value.

Ethics committee approval

Ethics committee approval (132) was obtained from the ethics committee of Istanbul Okan University on 27.01.2021.

Results

While 17.5% (n: 44) of the participants were male, 82.5% (n: 208) were female. The mean age of the participants was 31.44±7.67 years, their mean height was 166.50±8.51 cm, and their mean weight was 67.43±11.03 kg. Furthermore, the mean BMI value of the participants was found to be 24.36±3.87 kg/m^2.

When the marital status of the participants was evaluated, 55.2% were married (n: 139), and 44.8% were unmarried (n: 113). Moreover, 6.7% (n: 17) of the participants were high school graduates, 2.0% (n: 5) had an associate degree, 64.7% (n: 163) had a vocational high school degree, 16.7% (n: 42) had a graduate degree, 1.6% (n: 4) had a postgraduate degree and 8.3% (n: 21) had speciality in medicine. The occupation of the participants was as follows: 35.9% (n: 93) were midwives/nurses, 2.8% (n: 7) were pharmacists, 6% (n: 15) were physiotherapists, 6% (n: 15) were paramedic/emergency medical technicians, 2.4% (n: 6) were medical secretaries, 14.7% (n: 37) were dieticians, 9.1% (n: 23) were doctors, 12.3% (n: 31) were technicians, 7.1% (n: 18) were medical assistants, 2.4% (n: 6) were psychologists and 14.7% (n: 40) were other personnel.

While 34.5% (n: 87) of the participants were smokers, 64.5% (n: 165) were not. A total of 25.4% (n: 64) of them consumed alcohol, and 74.6% (n: 188) did not. Furthermore, 20.2% (n: 51) had a previously diagnosed chronic disease.

The BMI values of the participants were grouped according to gender. In this grouping, 2.3% of males (n: 1) and 3.4% (n: 7) of females were underweight (BMI<18.5), 70.5% of males (n: 31) and 56.7% (n: 115) of females were normal-weight (BMI=18.5-24.9), 25% of males (n: 11) and 31% (n: 63) of females were overweight (BMI 25-29.9), and 2.3% of males (n: 1) and 8.9% (n: 18) of females were obese (BMI≥30). There was no statistically significant difference between the BMI groups and the gender variable (p=0.283).

The most preferred nutritional supplements were vitamin D 31 (12.3%), vitamin B12 20 (7.9%), vitamin C 18 (7.1%), and multivitamins 16 (6.3%).

No statistically significant difference was found between the sub-dimensions of the Intuitive Eating Scale and the use of nutritional supplements. Those who have breakfast regularly were determined to rely more on hunger and satiety cues (p=0.047). Moreover, those who do not skip meals (0.002) and those who also have breakfast regularly ($p<0.001$) were found to have better body-food choice congruence. There was a positive significant relationship between the mean BMI value of the participants and their mean age ($p<0.001$). In other words, as the mean age of the participants increases, their mean BMI value also increases. A negative statistically significant relationship was found between the participants' BMI values and their intuitive eating scale scores ($p<0.001$). There was a significant relationship between BMI and intuitive eating (p=0.027). In other words, as BMI values increase, intuitive eating levels decrease.

Discussion

A total of 252 healthcare professionals were included in this study, which aimed to evaluate the nutritional habits, use of nutritional supplements and intuitive eating behaviours of healthcare professionals during the COVID-19 pandemic.

Intuitive eating is expressed as an eating style that focuses on eating for physical reasons, in which the individual relies on his/her understanding of and connections to hunger and satiety cues rather than emotional or environmental motivating factors [16]. It has been suggested that unconditional permission to eat any desired food based on intuitive eating cues, regardless of nutrient or calorie content, can reduce food overindulgence [17]. Furthermore, there are also studies showing that intuitive eating is affected by some parameters (such as age, gender, BMI, financial status, and occupation) [18-22].

In our study, no significant relationship was found between age and the total IES score (p=0.519). Similar to our result, two different studies reported that there was no significant relationship between the total IES score and age [10,18]. However, different from our results, Augustus et al. stated that the IES score decreased as the age increased [23].

No significant difference was found in our study between gender, smoking status, alcohol consumption status, presence of chronic disease, marital status and the mean IES total score ($p>0.05$) (Table 1). In their studies, Yayan [24] and Kuseyri [25] also reported similar results to our results.

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Table 1. Nutrition and nutritional supplemental habits of the participants by gender

		Male n (%)	Female n (%)	Total n (%)	p	X^2
Number of main meals	**1**	2 (4.5)	7 (3.4)	9 (3.6)	**0.002**	15.034
	2	11 (25.0)	115 (55.3)	126 (50.0)		
	3	30 (68.2)	78 (37.5)	108 (42.9)		
	4	1 (2.3)	8 (3.8)	9 (3.6)		
Status of having breakfast	**Yes**	29 (65.9)	152 (84.0)	181 (71.8)	0.337	0.922
	No	15 (34.1)	56 (26.9)	71 (28.2)		
Status of skipping meals	**Yes**	11 (25.0)	98 (47.1)	109 (43.3)	**0.022**	7.677
	No	7 (15.9)	29 (13.9)	36 (14.3)		
	Sometimes	26 (59.1)	81 (38.9)	107 (42.5)		
Which meal do you skip?	**Breakfast**	18 (40.9)	58 (27.8)	76 (30.2)	0.169	3.554
	Lunch	17 (38.6)	109 (52.4)	126 (50.0)		
	Dinner	2 (4.5)	12 (5.7)	14 (5.6)		
	Total	37 (84.0)	179 (85.9)	216 (85.7)		
Reason for skipping meals	**Lack of time**	25 (56.8)	75 (36.0)	100 (39.7)	**0.023**	13.067
	Do not have the habit	1 (2.27)	19 (9.1)	20 (7.9)		
	Do not want to eat	8 (18.1)	48 (23.0)	56 (22.2)		
	To lose weight	3 (6.8)	9 (4.3)	12 (4.8)		
	Forgetting	0 (0)	5 (2.4)	5 (2)		
	Other reasons	0 (0)	23 (11.0)	23 (9.1)		
	Total	37 (84.0)	179 (86.0)	216 (85.7)		
Number of snacks	**None**	9 (20.5)	35 (16.8)	44 (17.5)	0.212	4.507
	1	21 (47.7)	80 (38.5)	101 (40.1)		
	2	3 (29.5)	68 (32.7)	81 (32.1)		
	3 or more	1 (2.3)	25 (12.0)	26 (10.3)		
Use of nutritional supplements	**Yes**	8 (18.2)	62 (29.8)	70 (27.8)	0.118	2.447
	No	36 (81.8)	146 (70.2)	182 (72.2)		
	Total	44 (17.5)	208 (82.5)	252 (100)		

There was no significant difference between the unconditional permission to eat sub-dimension of IES and gender, smoking and alcohol consumption status, and presence of chronic disease (p>0.05). Only, unmarried participants were determined to give more unconditional permission to eat with a significant difference compared to married participants (p=0.048) and participants who received nutrition education compared to those who did not (p=0.011).

In Saunders et al.'s study conducted with Hispanic origin individuals in the US, while there was no difference according to gender in the sub-dimensions of Unconditional Permission to Eat and Body-Food Choice Congruence, males were found to have higher scores in the subdimension of Eating For Physical Rather Than Emotional Reasons [26]. Ruzanska and Warschburger reported in their study that males had higher scores in the sub-dimensions of Unconditional Permission to Eat and Reliance on Hunger and Satiety Cues and females in Body-Food Choice Congruence [19]. Some of studies that there was no significant relationship between the Body-Food Choice Congruence sub-dimension of the IES and gender. There was also no significant relationship in our study.

In our study, participants who consumed alcohol were found to have more Reliance on Hunger and Satiety Cues than those who did not (p=0.037) (Table 2). Similarly, male participants had more Reliance on Hunger and Satiety Cues than female participants (p=0.019) (Table 2). However, there was no statistically significant relationship between smoking status, presence of chronic disease, marital status and status having nutrition education, and the mean scores of the IES Reliance on Hunger and Satiety Cues sub-dimension (p>0.05).

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Table 2. Evaluation of the Knowledge Levels of the Participants about the IES

		IES Mean score	Unconditional permission to eat	Eating for physical rather than emotional reasons	Reliance on hunger and satiety cues	Body-food choice congruence
Gender	**Male (44)**	3.46±0.39	3.24±0.81	3.28±0.83	3.83±0.74	3.59±0.62
	Female (208)	3.33±0.44	3.15±0.64	3.24±0.82	3.52±0.79	3.60±0.71
		t=1.702 p=0.090	t=0.708 p=0.482	t=0.318 p=0.751	t=2.370 **p=0.019**	t=-0.086 p=0.931
Smoking status	**Yes (87)**	3.37±0.42	3.22±0.74	3.20±0.85	3.65±0.83	3.56±0.70
	No (165)	3.35±0.44	3.13±0.63	3.26±0.81	3.54±0.76	3.61±0.69
		t=0.481 p=0.631	t=0.996 p=0.320	t=-0.572 p=0.568	t=1.029 p=0.305	t=-0.497 p=0.620
Status of alcohol consumption	**Yes (64)**	3.41±0.43	3.15±0.71	3.25±0.85	3.76±0.77	3.67±0.63
	No (188)	3.34±0.44	3.17±0.66	3.24±0.81	3.52±0.78	3.57±0.72
		t=1.197 p=0.232	t=-0.132 p=0.895	t=0.087 p=0.930	t=2.095 **p=0.037**	t=0.961 p=0.337
Presence of chronic disease	**Yes (51)**	3.43±0.39	3.15±0.74	3.41±0.73	3.67±0.64	3.50±0.79
	None (201)	3.33±0.45	3.17±0.66	3.20±0.84	3.55±0.82	3.62±0.67
		t=1.438 p=0.152	t=-0.144 p=0.886	t=1.660 p=0.098	t=1.090 p=0.278	t=-1.021 p=0.308
Marital status	**Married (139)**	3.35±0.43	3.09±0.64	3.31±0.81	3.54±0.78	3.58±0.73
	Unmarried (113)	3.36±0.45	3.26±0.70	3.16±0.83	3.62±0.79	3.61±0.65
		t=-0.099 p=0.921	t=-1.974 **p=0.048**	t=1.462 p=0.145	t=-0.799 p=0.425	t=-0.414 p=0.680
Status of receiving nutrition education	**Yes (139)**	3.34±0.45	3.26±0.69	3.17±0.81	3.54±0.84	3.62±0.70
	No (113)	3.37±0.42	3.04±0.63	3.34±0.83	3.62±0.71	3.56±0.69
		t=-0.563 p=0.574	t=2.552 **p=0.011**	t=-1.610 p=0.109	t=-0.759 p=0.449	t=0.671 p=0.503

When evaluating the IES scores according to the occupations of the participants, pharmacists (3.54) had the highest IES scores followed by dieticians (3.52). We could not come across any study in the literature in which the IES scores of healthcare professionals were evaluated according to the occupation groups. In our study, when comparing BMI values, 2.3% of male participants and 8.9% of females were found to have obesity. It is gratifying that the results were below the average of Turkiye (obesity rate: 24.8%) [27]. There was no statistically significant difference between the BMI groups and the gender variable. In the evaluation of the nutritional habits of the participants, most of the females (55.3%) were found to have two meals and the majority of the males (68.2%) had three meals, and there was a statistically significant difference between gender in terms of the number of main meals consumed daily (p=0.002). In a study conducted with 200 teachers in Elazig, a city in Turkiye, almost half of the participants stated that they did not have the habit of having breakfast and that they skipped meals, and that the meal they skipped the most was lunch. Furthermore, 40% of the teachers stated that they skipped meals because they did not have time [20]. In an online study conducted with 341 participants from different occupational groups, 53.7% of the participants were found to have three main meals before the pandemic, while this rate decreased to 33.7% after the pandemic. This shows that skipping meals has increased after the pandemic [21]. In our study, there was a statistically significant difference between gender in terms of skipping meals (p=0.022) (Table 1). The study examining the nutritional habits of 127 police officers in England reported that most of them skipped meals. Almost all (87%) of the police officers stated that they skipped meals because they did not have time [22]. Different results show that the time, number and type of meals vary depending on occupational groups and working conditions. It shows that the increase in the workload of healthcare professionals, especially during the pandemic, affects

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their meal time. In their study, Ismail et al. emphasized that the frequency of skipping meals increased with the pandemic [28]. In Ulusoy's study examining the circadian rhythm and nutritional status of individuals working in shifts, 27% of healthcare professionals were noted to skip meals [29]. According to our results, 43.3% of the participants always skipped meals and 42.5% of them sometimes skipped meals. With the pandemic, the habit of skipping meals seems to have increased among individuals. When we look at the reasons for skipping meals, including in our study, not being able to have time was reported to be the most common reason. The results of studies conducted with healthcare professionals were similar [3,30]. In our study, the habits of the participants' habits of having snacks were questioned and a significant difference was found between gender (p=0.003). While males were found to prefer tea/coffee as a snack, women preferred fruit/dried fruits more. Furthermore, healthcare professionals might have used nutritional supplements to improve their immune systems, especially during the pandemic. A total of 27.8% of the participants answered "yes" to the question of using nutritional supplements or not, asked for this purpose. The majority of the participants stated that they were using nutritional supplements to maintain good health. In their study conducted during the COVID-19 pandemic, Kutlu et al. reported that 65% of the participants used nutritional supplements to strengthen their immune systems [31], while Mrityunjaya et al. stated that participants used nutritional supplements most frequently to strengthen their immune systems against viral infections [32]. In our study, the most preferred nutritional supplements were vitamin D (12.3%), vitamin B12 (7.9%), vitamin C (7.1%), and multivitamins (6.3%). In the study of Macit in which the nutritional habits of the participants were examined during the pandemic, one-third of the participants stated that they took nutritional supplements and they preferred vitamin D the most [21]. Different studies conducted during the pandemic reported different results. Participants used multivitamins and Omega-3 in one study [33] while healthcare professionals in Malaysia used Vitamin C and multivitamins [34]. University students used multivitamins and vitamin C [35], and 21% of healthcare professionals in our country used vitamin D, 17% vitamin C and 9% vitamin B12 [30] as nutritional supplements [30,36]. A study was conducted involving 324 nursing students during COVID 19. Students 39.8% were vitamin C, 25.1% were vitamin D, 19.6% were vitamin B12, 7.6% were Magnesium, 7.6% Zinc, 6.4% Multivitamin, 5.6% Probiotic, 0.6% Iron food/vitamin reported using [37]. Moreover, in our study, unmarried participants were determined to use significantly more nutritional supplements compared to married ones (p=0.001) and those who consumed alcohol than those who did not (p=0.020), and participants who had previously received nutritional education (p=0.037). There was no information in the literature on the use of nutritional supplements with similar categories. There was no significant difference between the use of nutritional supplements and gender.

A negative statistically significant relationship was found between the participants' BMI values and their intuitive eating scale scores ($p<0.001$). In other words, as BMI values increase, intuitive eating levels decrease. There was a statistically significant relationship between body mass index and intuitive eating (p=0.027).

In their study, Tylka et al. examined the relationship between the level of intuitive eating and some health indicators. As a result of the study, participants with high intuitive eating levels were determined to have lower BMI values [38]. This result shows similarities with our study.

In Duran et al.'s study, the IES score of obese participants was found to be statistically significantly lower than the other groups [39]. Smith and Hawks, on the other hand, similarly stated that those with high BMI values had lower IES scores [11]. The results of another study showed that underweight individuals had higher IES scores than other groups [40]. Similarly, a negative relationship was found between BMI values and IES scores in our study. In other words, the fact that individuals with high BMI values have a lower IES score supports the literature.

Duran et al. conducted a study examining the relationship between the intuitive eating levels of healthcare professionals and their nutritional habits. As a result of their study, they reported that individuals who eat intuitively receive a more nutritious diet and develop healthier eating behaviours than those who do not eat intuitively. In line with this, they have been noted to have positive eating models [39]. It is noteworthy that there is a limited number of studies examining the nutritional habits and intuitive eating status of individuals. In a controlled study conducted in Canada, education on nutrition and health was provided to females in the intervention group. The intuitive eating scale scores of the participants who received nutrition education were observed to increase significantly after the education compared to the control group [40]. We could not come across any study in the literature investigating the relationship between receiving nutrition education and the intuitive eating scale on healthcare professionals. The fact that our study was conducted with healthcare professionals shows that the level of awareness on this issue was high whether they have received nutrition education or not.

Conclusion

The findings from our study, along with previous studies, provide preliminary data suggesting that intuitive eating might have some benefits for both weight control and unbalanced eating behaviours, while there is a need for further studies to be conducted on the subject.

Conflict of Interests
The authors declare that there is no conflict of interest in the study.

Financial Disclosure
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Ethical Approval
Ethics committee approval (132) was obtained from the ethics committee of İstanbul Okan University on 27.01.2021.

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