Rigid dietary control, flexible dietary control, and intuitive eating: Evidence for their differential relationship to disordered eating and body image concerns

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A B S T R A C T

This study aimed to replicate and extend from Tylka, Calogero, and Danielsdottir (2015) findings by examining the relationship between rigid control, flexible control, and intuitive eating on various indices of disordered eating (i.e., binge eating, disinhibition) and body image concerns (i.e., shape and weight over-evaluation, body checking, and weight-related exercise motivations). This study also examined whether the relationship between intuitive eating and outcomes was mediated by dichotomous thinking and body appreciation. Analysing data from a sample of 372 men and women recruited through the community, this study found that, in contrast to rigid dietary control, intuitive eating uniquely and consistently predicted lower levels of disordered eating and body image concerns. This intuitive eating-disordered eating relationship was mediated by low levels of dichotomous thinking and the intuitive eating-body image relationship was mediated by high levels of body appreciation. Flexible control predicted higher levels of body image concerns and lower levels of disordered eating only when rigid control was accounted for. Findings suggest that until the adaptive properties of flexible control are further elucidated, it may be beneficial to promote intuitive eating within public health approaches to eating disorder prevention. In addition to this, particular emphasis should also be made toward promoting body acceptance and eradicating a dichotomous thinking style around food and eating.

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1. Rigid dietary control, flexible dietary control, and intuitive eating: evidence for their differential relationship to disordered eating and body image concerns

Promoting healthy, adaptive and sustainable patterns of eating are one of the many goals of public health approaches to eating disorder prevention (Shaw, Stice, & Becker, 2009; The National Eating Disorders Collaboration, 2012). Such prevention programs typically promote a flexible dietary approach over a rigid dietary approach, since research has reported consistent links between rigid dietary control (RC) and disordered eating (Smith, Williamson, Bray, & Ryan, 1999; Stewart, Williamson, & White, 2002; Timko & Perone, 2005; Westenhoefer, Stunkard, & Pudel, 1999; Westenhoefer et al., 2013). Whereas RC involves an all-or-none approach to eating (e.g., inflexible dietary rules dictating what, when and how much one should eat), flexible dietary control (FC) involves a graded approach to eating, defined by behaviours such as taking smaller servings of food to regulate weight, eating a variety of foods in limited qualities, and compensating at subsequent meals (e.g., opting for “healthy foods”) if “unhealthy” foods were consumed earlier on (Westenhoefer et al., 1999).

Although previous research has reported links between FC and positive health outcomes (Smith et al., 1999; Westenhoefer et al., 1999), Tylka, Calogero, and Danielsdottir (2015) recently challenged the idea of promoting FC strategies. Instead, these authors argue for clinical and public health context to promote intuitive eating, which is characterised by (a) having a strong connection with, and eating in accordance to, physiological hunger and satiety cues rather than on external or emotional cues and (b) recognising that all foods serve a variety of purposes (e.g., taste, energy) that is dependent on the context and situation. There are several reasons these authors made this claim: First, research has not consistently supported the link between FC and positive health outcomes (Provencher, Drapeau, Tremblay, Després, & Lemieux, 2003). In fact, studies have shown FC to be associated with increased levels of disordered eating (Timko & Perone, 2005). Second, strong correlations between FC and RC have been observed in several studies, calling into question whether FC and RC are distinct styles of eating behaviour (Shearin, Russ, Hull, Clarkin, & Smith, 1994; Westenhoefer et al., 2013). Third, intuitive eating has been consistently linked to numerous positive health outcomes, including lower levels of disordered eating, a lower body mass index (BMI), and a positive body image (Bruce & Ricciardelli, 2016; Van Dyke & Drinkwater, 2014).

To empirically investigate the claim that intuitive eating should be emphasised and promoted over FC, Tylka et al. (2015) examined the
association between RC, FC, intuitive eating and several health outcomes in a community sample. Whereas higher levels of RC predicted negative health outcomes, both intuitive eating and FC were significant and unique predictors of positive health outcomes, including higher positive affect, body appreciation and interoceptive awareness, and lower levels of negative affect, binge eating, food preoccupation, and BMI (Tylka et al., 2015). Critically, however, FC was a significant predictor of these outcomes only after its shared variance with RC was removed; in bivariate correlations, FC was unrelated to most health outcomes but positively and significantly related to rigid control, poor interoceptive awareness, binge eating, and food preoccupation. Tylka et al. (2015) made the following three conclusions in light of these findings. First, due to their strong correlation, FC strategies that are qualitatively distinct from RC strategies are yet to be elucidated. Second, until these distinct and adaptive FC strategies are identified, promoting FC may be detrimental as it may unintentionally promote RC. Third, encouraging intuitive eating, which seems to be a distinct construct from both FC and RC, might be a viable alternative for facilitating health and wellbeing.

This is the only study to have examined the relationship FC, RC, and intuitive eating and health outcomes in the same sample. Because Tylka et al. (2015) argued for the promotion of intuitive eating over FC in clinical and public health contexts, there is a need to validate and replicate these findings in a different sample and setting. The current study therefore aims to not only replicate Tylka et al. (2015) findings, but also extend from them in two important ways.

First, we intend on examining the relationship between RC, FC, and intuitive eating on a broader range of body image and disordered eating symptoms (i.e., over-evaluation of weight and shape, body checking, disinhibited eating, binge eating, weight-related reasons for exercising). Tylka et al. (2015) only assessed binge eating severity and food preoccupation as markers of disordered eating, which precludes any inference regarding the unique relationship between RC, FC, and intuitive eating on body image concerns and on other symptoms of disordered eating. This limitation is crucial, as specific cognitive and behavioural symptoms all contribute to the maintenance of disordered eating psychopathology in unique ways (Fairburn, Cooper, & Shafran, 2003; thus, establishing that a consistent and differential relationship exists between RC, FC, and intuitive eating on these diverse symptoms could, in the long-term, benefit prevention and intervention programs. For example, shape and weight over-evaluation is considered by cognitive-behavioural models (Fairburn et al., 2003) to be the core psychopathology of disordered eating symptomatology, where most dysfunctional body image (e.g., body checking) and eating behaviours (e.g., binge eating) stem from this over-evaluation. Before shape and weight over-evaluation is directly targeted during cognitive-behavioural interventions, initial treatment strategies are prescribed to indirectly reduce its influence on other disordered eating symptoms (e.g., dietary restraint, food preoccupation; Fairburn, 2008). Such strategies include, for example, weekly weighing as well as the “regular eating” technique. The regular eating technique is designed to target RC and rigid dietary restriction by promoting strategies that align with FC principles (e.g., eating from a wide variety of foods at structured, regular time in-
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