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US Registered Dietitian Nutritionists' Knowledge and Attitudes of Intuitive Eating and Use of Various Weight Management Practices

Julie T. Schaefer, PhD, RD; Melissa D. Zullo, PhD, MPH

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ABSTRACT

Background Researchers have been advocating for a new weight-inclusive paradigm that focuses on health rather than weight. One important component of this model is intuitive eating. Although registered dietitian nutritionists (RDNs) are the nation's food and nutrition experts, RDNs' knowledge of and attitudes toward intuitive eating and use of traditional or restrictive strategies are unknown.

Objective The purpose of this study was to characterize RDNs' knowledge of and attitudes toward an intuitive eating lifestyle and describe use of traditional weight management and nonrestrictive lifestyle practices with clients.

Design This was a cross-sectional study.

Participants A validated survey was distributed using online survey software to 88,834 RDNs.

Results There were 18,622 respondents who completed the survey (25%). The majority of RDNs were knowledgeable about intuitive eating, answering 71% of items correctly. The majority of RDNs had a positive view on each attitude item. RDNs who work in weight management reported using nonrestrictive/intuitive eating practices more than traditional/restrictive practices. RDNs who were women ($P<0.001$), had advanced education ($P<0.001$), worked in a private practice setting ($P<0.001$), completed at least one certificate of training in weight management ($P<0.001$), had more experience in weight management counseling ($P<0.001$), and had greater intuitive eating knowledge ($P<0.001$) were more likely to report greater use of nonrestrictive/intuitive eating practices.

Conclusions This study provides evidence that RDNs are using an intuitive eating approach more often than traditional weight management practices.

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THE NATIONAL HEALTH AND NUTRITION EXAMINATION Survey has been tracking the weight of Americans since 1960. At that time, the age-adjusted prevalence of adult obesity was 10%[1]; today, the prevalence has increased to 36%.[2] With the increase in prevalence, addressing obesity has become a national public health priority. Unfortunately, weight loss programs that promote restriction of calorie intake have demonstrated little long-term success. Few participants maintain weight loss and many gain back more weight than was lost during the program.[3-7] This has resulted in ethical concerns around recommending diets for weight loss when they have been shown to demonstrate long-term ineffectiveness and adverse effects.[5,8]

Recently, support has been growing for a nonrestrictive, weight-inclusive approach to nutrition, such as intuitive eating. Intuitive eating promotes health rather than weight loss, encourages eating based on internal cues of hunger and fullness, and emphasizes size acceptance.[8-13] There is evidence that intuitive eating is associated with a lower body mass index[10,14-16] and greater psychological well-being,[10,16] and inversely associated with eating disorder symptomatology.[10,16] Participants in intuitive eating interventions generally lose[17-24] or maintain[25-32] body weight, improve cardiovascular risk irrespective of weight loss,[26,33] and increase body satisfaction.[19,24,25,28,34-36] However, research is limited and further studies are needed.[11,12] The two approaches, the weight-inclusive approach such as the intuitive eating approach and the traditional weight loss paradigm, reflect a divide in the literature on the best approach for supporting overall health and well-being.[37]

Researchers have described Australian,[38] Canadian,[39,40] and British[41] RDNs' use of specific practices regarding weight management with clients. Although some maintain a focus on weight loss, many are moving toward a weight-inclusive paradigm with limitations because most RDNs have not fully adopted the approach.[39,40] Particularly, the degree to which size acceptance is encouraged may depend the client's weight.[40] In one study,[40] the majority of RDNs agreed that clients with a body mass index >30 should be

encouraged to lose weight, whereas another group believed weight loss should be a goal for obese clients with additional risk factors, but not for those without additional risk factors.[39]

Attitudes toward size acceptance vary among members of the dietetics profession.[39,42] Some RDNs are passionate about size acceptance with all clients, whereas others worry that it may lead to complacency, compromising attempts to improve health.[42] Further, some believe that size acceptance and weight loss can co-occur as a treatment goal, whereas others believe that size acceptance inherently involves removing the importance of weight or weight loss.[42] In the United States, RDNs' attitudes regarding obesity have been assessed[43,44]; however, weight management and weight-inclusive practices have not been examined. Globally, little research has been conducted to examine RDNs' understanding of and attitudes toward a nonrestrictive, weight-inclusive approach.[42]

The majority of RDNs report that it is the role of RDNs to help clients manage obesity[38,40]; however, the best approaches to do so are not fully understood. The Academy of Nutrition and Dietetics urges RDNs to remain current on the treatment and management of obesity. Therefore, it is important to understand the approaches RDNs are taking to address clients' weight concerns as a step to further RDN education and knowledge of best practices. Thus, the purpose of this study was to describe RDNs' knowledge of and attitudes toward an intuitive eating lifestyle and assess RDNs' use of traditional weight management and nonrestrictive lifestyle practices with clients.

MATERIALS AND METHODS

Participants

Contact information for all RDNs in the United States (N=88,834) was provided by the Commission on Dietetic Registration. This research used a two-step approach that involved validation of an instrument in a sample of the RDNs[45] and administration of the validated instrument to the remainder of RDNs. In the first step, a 10% (n=8,834) random sample of RDNs was selected to participate in the study to validate the instrument.[45] There were 1,897 (22%) respondents to Step 1. In Step 2, 2,857 RDNs were found to have provided an e-mail address that was nondeliverable. This resulted in the survey being sent to 76,912 RDNs. Those who reported they were retired (n=1,577) were excluded. This left 22,542 RDNs who responded to the survey (18,622 with complete responses and 2,023 with partial responses that were included in analyses where appropriate). Because no major changes were made to the instrument after Step 1,[45] data from the 1,897 Step 1 participants were included in the current study. The overall response rate was 25% (n=22,542).

Procedures

All RDNs were sent an e-mail message explaining the purpose of the study and requesting their participation. The purpose of the study was described generically ("knowledge, attitudes, and practices regarding weight management techniques") to avoid a selection bias of only those familiar with intuitive eating. The e-mail asked RDNs to follow a link to the survey website where they were prompted to provide consent. During a 3-month period, RDNs received the original and three reminder e-mail messages. This research was approved by the Kent State University Institutional Review Board.

Measures

Knowledge, Attitudes, and Practices. The previously developed and validated instrument[45] gauged RDNs' knowledge of and attitudes toward intuitive eating and use of traditional/restrictive and nonrestrictive practices with clients who expressed weight concerns. Knowledge of intuitive eating was measured with 14 true or false questions. Each question included a "do not know" response category. Attitudes toward intuitive eating were measured with seven items rated on a Likert scale (for the first item, 1=strongly do not support to 6= strongly support; for the remaining six items, 1=strongly disagree to 6=strongly agree). Each item also included a "do not know" response category to distinguish those who were not familiar with intuitive eating from those who had a neutral opinion regarding intuitive eating. To measure practices, participants were asked how often they used each of the 17 strategies to address clients' weight concerns (1=never to 5=usually). In Step 1, validation of the instrument, seven items represented restrictive/traditional weight management practices, whereas 10 items represented nonrestrictive/intuitive eating strategies.[45]

Descriptive Characteristics. Data were collected on sex, age, race, ethnicity, highest level of education completed, main practice setting, state of practice, whether they had completed a certificate of training in weight management, and whether they counseled overweight and/or obese clients for weight management.

Data Analysis

Mean age and frequencies for sex, race, highest education level, practice setting, and certification in adult or pediatric weight management were used to describe the sample. A pairwise deletion approach (available case analysis) was used to analyze all available data. Frequencies were used to display RDNs' knowledge of and attitudes toward intuitive eating and use of restrictive/traditional and nonrestrictive/intuitive eating practices.

Likert scale items are ordinal in nature; however, composite scores calculated from Likert scales can be treated as interval-level and parametric tests can be used to analyze such scores.[46-49] Using this approach, total scores were calculated for each of the four factors. A total knowledge score was calculated by taking the sum of the 14 questions answered correctly from the knowledge section of the survey (range=0 to 14). A total attitudes score was calculated by taking the sum of the five items with a higher score reflecting more positive attitudes toward the intuitive eating lifestyle (range=5 to 25). Two attitudes items did not load onto the factor in previous validation and were used for descriptive purposes only (not total score). Any attitude response reported as "do not know" was treated as a nonresponse. Participants who answered "do not know" to at least one item would not have a total attitudes score. A total score was calculated for both restrictive/traditional (range=7 to 35) and nonrestrictive/intuitive eating (range=10 to 50) practices.