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Reflections of academic anxiety on diet and eating behaviors: the relationship between exam stress and nutrition in young adults

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ABSTRACT

Aims: Test anxiety/stress may influence eating behaviors and diet quality. The purpose of this study was to investigate the relationships between exam stress and eating attitudes, behaviors, and diet quality in young adults.

Methods: This study was conducted with 557 young adults via a voluntary sampling method via online platforms (Facebook, Instagram, WhatsApp, etc.) between April and May 2025. The survey form used to collect data consisted of four sections: an introductory information form covering sociodemographic characteristics, the Westside Test Anxiety Scale, the Eating Attitudes Test (EAT-26), and the Mediterranean Diet Adherence Screener (MEDAS). Data analysis was performed with IBM SPSS Statistics 26.0 and AMOS 24. Independent samples t tests, one-way analysis of variance (ANOVA), Pearson correlation analysis and path analysis were used.

Results: Most of the participants exhibited normal eating attitudes (74.3%) and moderate Mediterranean diet characteristics (57.6%). Compared with those with normal eating behaviors, those with abnormal eating behaviors had significantly lower MEDAS scores (6.2±2.13 vs. 6.9±2.36, p=0.003) and significantly higher Westside Test Anxiety Inventory scores (33.0±9.30 vs. 28.4±9.12, p<0.001). The Westside Test Anxiety Inventory score was significantly positively correlated with the EAT-26 score (r=0.29, p<0.001) and body weight (r=0.10, p=0.01). Test anxiety significantly predicted EAT-26 scores (β=0.292, p<0.001), and approximately 8.5% of the variance in eating attitudes and behaviors was explained by test anxiety level (R^2=0.085). The effect of test anxiety on the MEDAS total score was not statistically significant (β=−0.055, p=0.195).

Conclusion: As the level of test anxiety increased, abnormal eating behavior also increased, and test anxiety was positively correlated with abnormal eating behavior.

Keywords: Young adult, test anxiety, eating attitudes and behaviors, mediterranean diet

INTRODUCTION

Dreams of a better future, striving for high academic achievement, and environmental expectations lead to anxiety, fear, and worry about the future in young adults.[1] Test anxiety is a situational, physiological, behavioral, and cognitive form of anxiety that affects students during exams or other assessment situations; prevents individuals from revealing their true performance; and is controlled by individuals' thought patterns, personalities, and locus of control.[2] A total of 10–40% of students experience varying degrees of test anxiety, whereas 15-22% experience severe test anxiety.[3] Test anxiety can negatively affect students' health by causing physical, psychological or social problems.[4]

One of the health indicators that is negatively affected by stress and anxiety is eating attitudes and behaviors.[5] It has been reported that stress increases external food-related signals, which can cause people to eat more in stressful situations in general.[6,7] Especially during the exam period, increased psychological distress, time constraints, disrupted routines and negative self-care behaviors can lead to weight gain or loss. In addition to increased food consumption, stressed individuals prefer more snacks and consume foods rich in fat and sugar.[7] This situation can result in weight gain and obesity. Stress reportedly leads to an increase in unhealthy food consumption and a decrease in healthy food consumption.[8] This has been attributed to the activation of the hypothalamic-pituitary-adrenal (HPA) axis under stress and the release of stress hormones such as cortisol.[9] These hormones influence reward processing and motivation pathways in the brain, contributing to an increased desire for high-energy, palatable foods.[10,11]

Test anxiety and academic stress have been found to be related to diet quality, and test anxiety and academic stress, in particular, have been found to negatively affect adherence to the Mediterranean diet.[12] The Mediterranean diet, which is rich in polyphenols, has been suggested to be associated with the prevention of depression and anxiety.[13] While recent

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studies have also shown a bidirectional relationship between excessive anxiety or depression levels, abnormal eating behaviors, and greater eating disorder psychopathology,[14,15] studies investigating the combined effects of test anxiety on eating attitudes and diet quality in young adults are lacking. At the national level, the number of studies in our country examining these topics in detail is limited. Considering the large number of students experiencing exam anxiety/stress, this study aims to investigate the effects of exam/test anxiety on eating attitudes and diet quality.

METHODS

Ethics

The study was carried out with the permission of the Karamanoğlu Mehmetbey University Health Sciences Scientific Researches and Publication Ethics Committee (Date 05.03.2025, Decision No: E-15466469-100-249264; 03-2025/31).All procedures were carried out in accordance with the ethical rules and the principles of the Declaration of Helsinki.

Study Design and Sample Selection

This cross-sectional study was conducted between April and May 2025, with 557 individuals identified through voluntary sampling. The sample size was calculated via the G*Power 3.1 program for post hoc power analysis. In this context, F tests → linear multiple regression: Fixed model, R^2 deviation from zero option was applied for the linear regression model, and when the effect size was calculated as f^2=0.15, the significance level was α=0.05, and the statistical power was 99.9%, the current sample size (n=557) was sufficient for both regression analyses and path analysis. The exclusion criteria were being under 18 or over 21 years of age, having a diagnosed psychological/psychiatric disorder, using psychiatric medication, and following a special diet or nutritional model. The study included 557 volunteer young adults aged 18-21 years who resided in Turkiye and were preparing for the university entrance exam. Participants were recruited through online platforms (Facebook, Instagram, WhatsApp), and data were collected via an online survey. Those who volunteered to participate in the study were informed about the purpose and scope of the study through a prepared text online, and consent was obtained from the participants. The link was shared online via Google Forms, and volunteers completed the online survey.

Data Collection

The questionnaire used to collect the data of the study consists of four sections: an introductory form including sociodemographic characteristics, the Westside Test Anxiety Scale, the EAT-26 and the MEDAS to determine diet quality.

Introductory Form

The introductory information form consisted of questions regarding the participants' sociodemographic characteristics (age, sex, income, smoking/alcohol use, height, body weight, and number of daily main meals and snacks). Individuals' self-reported body weight and height were used, and body mass index (BMI) was calculated by dividing body weight (kg) by the square of height (m^2). BMI was evaluated according to the World Health Organization (WHO) classification. A body composition index of less than 18.50 kg/m² was classified as underweight, 18.50-24.99 kg/m² as normal, 25.0-29.99 kg/m² as overweight, and 30.0 kg/m² and above as obese.[16]

Westside Test Anxiety Scale

The Westside Test Anxiety Scale was used to measure students' test anxiety levels. Developed by Driscoll[17] and validated for Turkish by Totan and Yavuz,[18] the scale consists of 11 items and a five-point Likert-type rating. The participants' responses are scored as 5 for "Always True," 4 for "Usually True," 3 for "Occasionally True," 2 for "Rarely True," and 1 for "Never True." The scale, which does not include reverse-coded items, allows for scores ranging from 11-55. A higher total score on the scale is associated with increased test anxiety.

Eating Attitudes Test (EAT-26)

The participants' eating behaviors were assessed with the EAT-26, developed by Garner and colleagues[19] and adapted into Turkish by Ergüney-Okumuş and Sertel-Berk.[20] The scale consists of a total of 26 items. The participants were asked seven questions about their demographic information, 26 questions about their eating habits, and five statements about their eating behaviors. The Cronbach's alpha internal consistency coefficient was 0.84, and the test-retest stability coefficient was 0.78. A total score of 20 or higher was considered "abnormal eating behavior," whereas a score below 20 was considered "normal eating behavior".

Mediterranean Diet Adherence Screener (MEDAS)

The Mediterranean Diet Adherence Screening (MEDAS), developed by Martínez-González et al.[15] and whose validity and reliability were confirmed in Turkiye by Pehlivanoğlu et al.,[21] was used. The scale consists of 14 questions about food consumption. The total MEDAS score is calculated by assigning a score of 1 or 0 to each question on the basis of food consumption. A total MEDAS score of≤5 is defined as "poor," a score of 6-9 as "moderate," and a score of≥10 as "good".

Statistical Analysis

IBM SPSS Statistics 26.0 and AMOS 24 were used to analyze the data. Descriptive statistics are presented as the means, standard deviations, frequencies, and percentages. The normal distribution assumption of the continuous variables related to the scales was evaluated by examining the skewness and kurtosis values; it was determined that all values were within the normal distribution limits. For categorical variables, two-group variables were analyzed via the independent samples t test, and variables with three or more groups were analyzed via one-way ANOVA. Relationships between scales and their subdimensions were evaluated via Pearson correlation analysis. The effects of test anxiety on diet and eating behaviors were evaluated via path analysis and AMOS 24 program. In the analyses, the level of statistical significance was accepted as $p<0.05$.

RESULTS

The participants' general characteristics, eating attitudes, dietary characteristics, and anthropometric measurements are presented in Table 1. A total of 56.2% of the participants were female, and the mean age was 19.4±1.34 years. The mean BMI of the participants was 21.8±3.43 kg/m², and 45.1% had an average income.

Table 1. Participants' general characteristics, anthropometric measurements, eating behavior and dietary patterns

		Total (n=557)
Sex n (%)	Female	313 (56.2)
	Male	244 (43.8)
Income status n (%)	Under minimum wage	142 (25.5)
	Minimum wage	251 (45.1)
	Above the minimum wage	164 (29.4)
Smoking n (%)	Yes	137 (24.6)
	No	420 (75.4)
Alcohol n (%)	Yes	85 (15.3)
	No	472 (84.7)
MEDAS	Low	195 (35.0)
	Moderate	321 (57.6)
	High	41 (7.4)
EAT-26	Normal eating behavior	414 (74.3)
	Abnormal eating behavior	143 (25.7)
Age (years, mean±SD)		19.4±1.34
Body weight (kg, mean±SD)		63.0±13.16
Height (cm, mean±SD)		169.5±9.84
BMI (kg/m², mean±SD)		21.8±3.43
Main meals (mean±SD)		2.5±0.65
Snacks (mean±SD)		1.5±1.06

BMI: Body mass index, EAT-26: Eating Attitudes Test-26, MEDAS: Mediterranean Diet Adherence Screener

The participants' test anxiety, eating attitudes, and Mediterranean diet characteristics are presented in Table 2. The participants' Westside Test Anxiety Scale, EAT-26, and MEDAS scores were 31.9±9.46, 15.0±9.11, and 6.4±2.21, respectively. No significant difference was found between the levels of Mediterranean diet characteristics in terms of the Westside Test Anxiety Scale score and the EAT-26 score (p>0.05).

Test anxiety and Mediterranean diet characteristics according to eating attitudes and behaviors are presented in Table 3. Compared with those with normal eating behavior, those with abnormal eating behavior had significantly lower MEDAS scores (6.2±2.13 vs. 6.9±2.36, p=0.003), while their Westside Test Anxiety Scale scores were significantly higher (33.0±9.30 vs. 28.4±9.12, p<0.001).

Table 3. Exam anxiety and Mediterranean diet characteristics according to participants' eating attitudes and behaviors

	EAT-26				
	Normal eating behavior (n=414)	Abnormal eating behavior (n=143)	Mean difference 95% CI	p value	Cohen's d
WestsideTest Anxiety Scale total score (mean±SD)	28.4±9.12	33.0±9.30	4.60 (2.84, 6.36)	<0.001	0.50
MEDAS total score (mean±SD)	6.9±2.36	6.2±2.13	-0.65 (-1.06, -0.23)	0.003	0.29
BMI (kg/m², mean±SD)	21.7±3.26	21.8±3.89	-0.06 (-0.72, 0.59)	0.85	0.02

Independent sample t test. Cohen's d interpretation: d=0.20 (small), d=0.50 (medium), d=0.80 (large). BMI: Body-mass index; EAT-26: Eating Attitudes Test-26, MEDAS: Mediterranean Diet Adherence Screener

The correlations between participants' test anxiety, eating attitudes, Mediterranean diet characteristics, and anthropometric parameters are presented in Table 4 and Figure 1. Westside Test Anxiety Scale scores were significantly positively correlated with EAT-26 scores (r=0.29, p<0.001) and body weight (r=0.10, p=0.01). No significant correlations were found between the other components.

Table 4. Correlations between participants' test anxiety, eating attitudes, Mediterranean diet characteristics, and anthropometric parameters

	Westside test anxiety scale total score		EAT-26 total score		MEDAS total score	
	r	p	r	p	r	p
MEDAS total score	-0.05	0.19	0.07	0.07	-	-
Westside test anxiety scale total score	-	-	0.29	<0.001	-0.05	0.19
EAT-26 total score	0.29	<0.001	-	-	0.07	0.07
BMI	0.03	0.43	0.003	0.94	-0.04	0.26
Body weight	0.10	0.01	0.002	0.96	-0.02	0.63

Pearson correlation, BMI: Body mass index, EAT-26: Eating Attitudes Test-26, MEDAS: Mediterranean Diet Adherence Screener

Table 2. Participants' test anxiety, eating attitude behavior, and Mediterranean diet characteristics

	Total (n=557)	MEDAS				
		Low (n=195)	Moderate (n=321)	High (n=41)	p value	η^2 (eta squared)
Westside test anxiety scale total score (mean±SD)	31.9±9.46	31.7±9.44 (30.40, 33.07)	32.4±9.41 (31.38, 33.44)	28.8±9.56 (25.78, 31.82)	0.06	0.01
EAT-26 total score (mean±SD)	15.0±9.11	17.7±10.10 (14.54, 20.92)	15.0±9.33 (14.07, 16.12)	14.3±8.43 (13.19, 15.57)	0.10	0.008
MEDAS total score (mean±SD)	6.4±2.21	4.1±1.04 (3.97, 4.27) a	7.2±1.02 (7.12, 7.34) b	10.9±1.46 (10.49, 11.41)c	<0.001	0.76
BMI (mean±SD)	21.8±3.43	22.2±3.89 (21.65, 22.75)	21.5±3.19 (21.24, 21.94)	21.5±2.69 (20.73, 22.43)	0.12	0.007

η^2 and one-way ANOVA, η^2 interpretation: .01=small, .06=medium, .14=large. BMI: body mass index, EAT-26: Eating Attitudes Test-26, MEDAS: Mediterranean Diet Adherence Screener. Differences between groups were evaluated via the lettering method, and multiple comparisons were evaluated via Bonferroni correction.

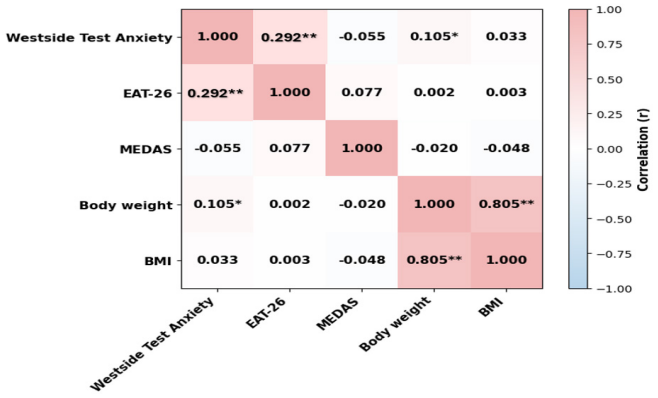

Figure 1. Correlation matrix among westside test anxiety, EAT-26, MEDAS, body weight, and BMI.

BMI: body mass index, EAT-26: Eating Attitudes Test-26, MEDAS: Mediterranean Diet Adherence Screener. Significance levels: *p<0.05, **p<0.001.

Path analysis results showing the effects of test anxiety on diet and eating attitudes and behaviors are given in Table 5 and Figure 2. According to the path analysis results, anxiety level has a significant positive effect on abnormal eating attitudes and behaviors. Test anxiety significantly predicted EAT-26 scores (β=0.29, p<0.001). The proportion of variance explained by the model for EAT-26 scores was R^2=0.085. The effect of test anxiety on the total MEDAS score was not statistically significant (β=−0.05, p=0.19).

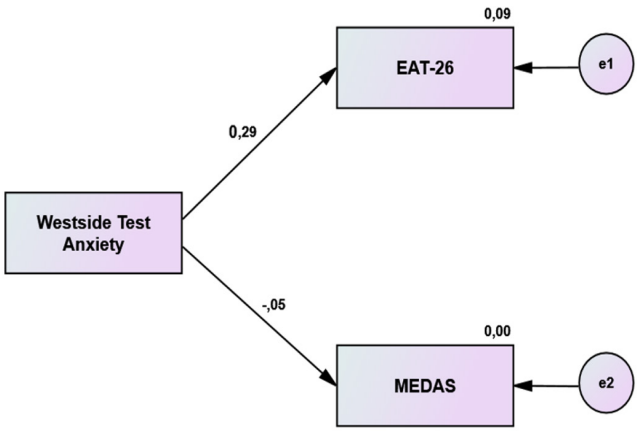

Figure 2. Effects of test anxiety levels on eating attitudes and diet quality.

A path analysis model was created to reveal the effects of test anxiety levels on eating attitudes and diet quality. Path analysis based on structural equation modeling (SEM). The model tested whether two dependent variables were significantly predictive of EAT-26 scores and MEDAS scores. The dependent variables were the EAT-26 and MEDAS scores, whereas the independent variable was the total score on the Westside Test of Anxiety. Two-way arrows represent the correlation (r) between the scales, and the one-way arrows represent the standardized beta coefficients (β). The term "e" represents the margin of error, whereas the number in the dependent variable represents the explanatory variance of the independent variables in the dependent variable. EAT-26: Eating Attitudes Test-26, MEDAS: Mediterranean Diet Adherence Screener

DISCUSSION

This study investigated the relationship between test anxiety and nutritional status in young adults and revealed that test anxiety scores were higher in those with abnormal eating behaviors than in those with normal eating behaviors and that test anxiety was significantly linearly correlated with body weight and abnormal eating behaviors. It was concluded that test anxiety was not significantly correlated with BMI or MEDAS.

A strong link has been noted between stress levels and negatively impacting eating habits.[22,23] When stress levels increase, unhealthy eating behaviors, such as excessive junk food consumption or the disruption of daily eating habits, become more common. The high preference of young adults for unhealthy snacks may stem from stress and/or lack of time.[23] Anxiety is also known to be influenced by multiple lifestyle factors, including dietary habits, exercise routines, sleep quality and psychological characteristics.[24] One study reported that students' total energy expenditure and physical activity levels during the exam period were significantly lower than those during the education period (p<0.05).[25] Our study revealed a weak positive correlation between body weight and test anxiety. This may be attributed to insufficient physical activity and irregular eating habits during the test anxiety period. Although there are opinions that body weight increases with the transition to university life, in one study, 56.3% of the participants reported an increase in their body weight after starting university, which was significantly related to stress-induced eating habits while studying for exams (p=0.01).[26] It has been shown that stress can negatively impact individuals' unhealthy food choices (high-energy, fatty, and sugary foods).[27]

Stress has been shown to affect homeostatic regulation of food intake and hedonic appetite control and lead to an increase in energy intake. It has also been suggested that stress is positively associated with eating frequency, the consumption of palatable foods, binge eating and emotional eating.[28] Individuals' reactions and responses to stress, or the ways they confront it, vary. It has been reported that stress can contribute to the triggering of disordered eating habits, and students may exhibit symptoms of stress-related eating disorders.[23] During stressful times, excessive food intake or inadequate nutrition can be a coping mechanism that helps individuals find solace and peace, and this process can manifest as eating disorders, undereating, skipping meals, or overeating.[29] There is considerable evidence suggesting a link between eating behavior and stress.[30-32] Studies have revealed positive correlations between EAT-26 scores and

Table 5. Path analysis results showing the effects of test anxiety on diet and eating attitudes and behaviors

Dependent variable	Path	Independent variable	B	S.E.	β (beta) 95% (lower-upper)	p	R^2
EAT-26	<---	Westside test anxiety	0.28	0.04	0.292 95% CI (0.36, 0.20)	<0.001	0.085
MEDAS	<---	Westside test anxiety	-0.01	0.01	0.055 95% CI (-0.03, 0.01)	0.195	0.030

B: Unstandardized path coefficient; β (Beta): Standardized path coefficient, R2: Proportion of variance explained in the dependent factor, S.E.: Standard error. EAT-26: Eating Attitudes Test-26, MEDAS: Mediterranean Diet Adherence Screener

depression, anxiety, and stress scores.[30,31] In our study, test anxiety was linearly and significantly related to abnormal eating behavior. Test anxiety significantly predicted EAT-26 scores, and approximately 8.5% of the variance in eating attitudes and behaviors was explained by test anxiety levels. Increased test anxiety was found to lead to abnormal eating behavior. Another study conducted with young adults revealed a significant positive correlation between perceived stress levels and eating disorders, and logistic regression revealed that perceived stress was a significant determinant of the risk of disordered eating.[32] In particular, stress has been reported to trigger binge eating and loss of control over food intake.[33] During stress, the activation of the hypothalamus-pituitary-adrenal axis and the release of stress hormones such as cortisol contribute to increased appetite, affecting reward processing and motivation pathways in the brain.[10,11] Studies have shown that students with higher levels of stress are more likely to engage in restrictive eating habits as a potential coping mechanism.[32,33] Furthermore, stress and bulimia/food obsession are more prominent, suggesting that high stress may contribute to impulsive eating episodes, emotional eating, or increased preoccupation with food.[32]

Focusing on the relationship between BMI and test anxiety, one study reported a significant negative relationship between BMI and anxiety status ($r=-0.26$, $p<0.01$),[34] whereas another study reported that depression anxiety stress scores were not associated with BMI in multiadjusted models.[30] Similarly, a study examining the relationship between BMI and stress levels in young adults (n=172) reported that stress did not differ significantly across any BMI category.[35] Our study also revealed no significant relationship between BMI and test anxiety. Individuals under stress often experience changes in their diet, such as increased consumption of processed foods, skipping meals, and irregular eating habits. Poor eating habits and a sedentary lifestyle can lead to deterioration in body composition. However, body weight and BMI may not differ significantly between periods of exam stress and normal periods. This is due to differences in muscle and fat distribution percentages between the two periods and the inability to explain the current situation with respect to BMI. Because the balance between increasing fat mass and decreasing muscle mass does not change body weight, BMI levels can remain the same.[4]

It has been suggested that higher adherence to the Mediterranean diet in university students is associated with lower levels of depression and stress.[36] A study (n=1053) revealed that a 1-point increase in Mediterranean diet characteristics decreased depression scores by 3 units and anxiety scores by 3.4 units ($p<0.001$).[35] Another study (n=1347) revealed that Mediterranean diet characteristics can reverse the effects of test anxiety and academic stress.[12] In our study, although MEDAS and test anxiety were not significantly correlated, this may be attributable to the fact that the majority of participants (57.6%) exhibited moderate levels of Mediterranean diet characteristics. The results may have differed if participants' levels of Mediterranean diet adherence had been more uniformly distributed. A key consideration is that the levels of these symptoms may be dependent on different sociodemographic variables. This may also be due to sample characteristics. Similarly, in another study conducted with university students (n=125), no significant correlation was found between Mediterranean diet characteristics and stress ($p=0.16$, $r=0.13$) or anxiety ($p=0.07$, $r=0.16$) scores.[37] Methodological and sampling differences across studies may explain the differences in study results. However, the literature has largely focused on the link between stress and eating within a single country. Because participants often share similar eating habits and other psychological and environmental characteristics that may be linked to stress, the results may not be generalizable to other countries. Furthermore, conducting studies in a single country makes it difficult to compare studies across different nations.[6] The relationships among stress, depressive symptoms, and unhealthy eating vary significantly across countries, and dietary patterns depend not only on individual factors but also on social and political factors.[38] In light of these results, it would be beneficial to compare individuals from different nationalities and examine whether nationality influences the relationship between stress and dietary preferences. Furthermore, personalized stress management interventions that address maladaptive coping strategies associated with stress-related eating behaviors are gaining importance.[32] Providing nutrition and stress reduction training via a multidisciplinary team consisting of dietitians and psychologists before and during exam periods to ensure healthy stress management may be beneficial.[39]

Limitations

This study has several limitations. First, the cross-sectional design of the study does not reflect causality. Since the study was conducted in a specific population in Turkiye, the generalizability of the findings may be limited. Because participation in our study was voluntary, the sample was intended to be representative of the young adult population experiencing test anxiety in Turkiye; however, it is acknowledged that there may be limitations in representativeness due to the sampling method. Additionally, all the data, including body weight and height measurements, were self-reported. Therefore, there may be differences in objectively measurable variables (e.g., BMI). While test anxiety, Mediterranean diet characteristics, and eating attitudes were estimated via validated scales, these scores may not fully reflect the true situation. Another potential limitation is that the data are based on participants' self-reports. Self-reported data may not reflect the norm or may lead to inaccurate statements. Despite these limitations, the findings of this study are valuable for guiding future research because of the underresearched topic in Turkiye and the large sample size.

CONCLUSION

The findings of this study revealed that test anxiety predicted and negatively influenced eating attitudes and behaviors by 8.5%. Test anxiety may negatively affect diet quality through abnormal eating mechanisms. Considering that test anxiety causes abnormal eating behaviors, stress reduction intervention programs have come to the forefront. It may be

beneficial to develop policies that encourage healthy eating habits and stress-reducing activities and to provide training by an expert team to ensure healthy stress management before and during exam periods. However, follow-up studies with large samples designed to address various factors are needed. As a result, it is important to conduct studies that evaluate the effects of interventions focused on reducing exam stress on eating attitudes and behaviors.

ETHICAL DECLARATIONS

Ethics Committee Approval

The study was carried out with the permission of the Karamanoğlu Mehmetbey University Health Sciences Scientific Researches and Publication Ethics Committee (Date 05.03.2025, Decision No: E-15466469-100-249264; 03-2025/31).

Informed Consent

Written informed consent was obtained from all individual participants prior to their inclusion in the study. Participants were fully informed about the study's aims, procedures, potential risks and benefits, and their rights-including the right to withdraw at any time without consequence. All participants voluntarily signed a written informed consent form.

Peer Review Process

This manuscript was subject to external peer review.

Conflict of Interest

The authors declare no conflicts of interest related to this study.

Financial Disclosure

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Author Contributions

Concept: S.İ.I., H.B.; Design: S.İ.I., H.B.; Control: S.İ.I., H.B.; Data collection and/or processing: S.İ.I., H.B.; Analysis and/or interpretation: S.İ.I., H.B.; Literature review: S.İ.I., H.B.; Article writing:S.İ.I., H.B.; Critical review: All authors.

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