

## The Relationship between Parental Support for Child Healthy Eating and Healthy Eating Self-Efficacy

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### ABSTRACT

**Aim:** This study was conducted to evaluate the relationship between family support for healthy eating and healthy eating self-efficacy.

**Material and Methods:** The study was conducted as descriptive and relational. A total of 621 students aged 8-10 attending the 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> grades who meet the inclusion criteria and agree to participate in the study. Data were collected using the “Descriptive Information Form”, “Healthy Eating Family Support Scale” and “Healthy Eating Self-Efficacy Scale”. The demographic data were analyzed using the numbers and percentages. The relationship between family support for healthy eating and self-efficacy for healthy eating was evaluated by Pearson correlation coefficients, and the effect of family support for healthy eating on healthy eating self-efficacy was evaluated by simple regression analysis.

**Results:** When the family support scale for healthy eating of children is examined between the total score averages and the total score averages of healthy eating self-efficacy scale; the family support scale for healthy eating has been determined to have a medium positive relationship between the total score averages of children and the total score averages of healthy eating self-efficacy (respectively;  $r=0.489$ ;  $\beta=0.489$ ;  $p<0.001$ ), and 24% of the factors affecting healthy eating self-efficacy of children were described with the average family support points for healthy eating of children ( $F=194.651$ ,  $p<0.001$ ).

**Conclusion:** As a result of this study; as children's family support for healthy eating increases, their healthy eating self-efficacy increases. In addition, family support for healthy eating predicts healthy eating self-efficacy.

**Keywords:** Healthy eating; family supports; self efficacy.

## Çocuklarda Sağlıklı Yeme ile İlgili Aile Desteği ve Sağlıklı Yeme Öz Yeterliliği Arasındaki İlişki

### ÖZ

**Amaç:** Bu çalışma, çocuklarda sağlıklı yeme ile ilgili aile desteği ve sağlıklı yeme öz yeterliliği arasındaki ilişkiyi değerlendirmek amacıyla yapılmıştır.

**Gereç ve Yöntemler:** Çalışma tanımlayıcı, kesitsel ve ilişkisel olarak yapılmıştır. Çalışmanın dahil etme kriterlerine uyan ve çalışmaya katılmayı kabul eden, yazılı ebeveyn onam formu olan 2., 3., ve 4., sınıfa devam eden 8-10 yaş aralığındaki 621 öğrenci katılmıştır. Veriler, “Tanımlayıcı Bilgi Formu”, “Sağlıklı Yeme ile İlgili Aile Desteği Ölçeği” ve “Sağlıklı Yeme Öz Yeterlilik Ölçeği” kullanılarak toplanmıştır. Çocukların tanımlayıcı bilgilerinin değerlendirilmesinde sayı, yüzde ve ortalama analizleri kullanılmıştır. Sağlıklı yeme ile ilgili aile desteği ve sağlıklı yeme öz yeterliliği arasındaki ilişki pearson korelasyon analizi ile, sağlıklı yeme ile ilgili aile desteğinin sağlıklı yeme öz yeterliliği üzerine etkisi basit regresyon analizi ile değerlendirilmiştir.

**Bulgular:** Çocukların sağlıklı yeme ile ilgili aile desteği ve sağlıklı yeme öz yeterlilik toplam puan ortalamaları arasındaki ilişki incelendiğinde; çocukların sağlıklı yeme ile ilgili aile desteği toplam puan ortalamaları ve sağlıklı yeme öz yeterlilik puan ortalamaları arasında pozitif yönde orta düzeyde anlamlı bir ilişki olduğu (sırasıyla  $r=0,489$ ;  $\beta=0,489$ ;  $p<0,001$ ) belirlenmiştir. Çocukların sağlıklı yeme öz yeterliliğini etkileyen faktörlerin %24'ünün çocukların sağlıklı yeme ile ilgili aile desteği puan ortalamaları ile açıklandığı bulunmuştur ( $F= 194,651$ ,  $p<0,001$ ).

**Sonuç:** Bu çalışmanın sonucunda; çocukların sağlıklı yeme ile ilgili aile destekleri arttıkça sağlıklı yeme öz yeterlilikleri artmaktadır. Ayrıca çocukların sağlıklı yeme ile ilgili aile destekleri, sağlıklı yeme öz yeterliliklerini yordamaktadır.

**Anahtar Kelimeler:** Sağlıklı yeme; aile desteği; öz yeterlilik.

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## INTRODUCTION

Adequate and balanced nutrition forms the basis of health and is defined as the intake of the nutrients needed by the individual (1). It is one of the important factors that positively affect physical, mental, emotional and social development in school-age children (2). It is emphasized that unhealthy nutrition is an issue that should be taken into consideration in terms of causing a decrease in the child's learning potential as well as causing diseases (3).

Nutritional habits are important in terms of being acquired during childhood and affecting the diet in adulthood. Some studies predict that 70-80% of children who are obese in childhood will experience obesity in adulthood (4,5). Therefore, it is important to provide children with education on healthy nutrition starting from the school period when healthy behaviors are formed or to examine studies including factors affecting healthy nutrition. It is emphasized that it is a more rational approach to prevent diseases that may be caused by unhealthy nutrition by making healthy nutrition a behavior instead of treating diseases that may occur due to unhealthy nutrition (6). Such an important concept is negatively affected by improper nutritional behaviors (7-9).

In the literature, it has been found that school-age children mostly do not eat breakfast, frequently eat bagels and biscuits at school, have problems in fruit and vegetable consumption, and frequently consume fast foods, energy drinks and unhealthy snacks (7,8,10,11). Especially in the literature, it is emphasized that it is important to raise awareness of healthy eating in children, and this can be achieved by increasing the self-efficacy levels of children regarding healthy eating (10-12).

Healthy eating self-efficacy is defined as the child's perceived level of competence to choose and prefer healthier foods (12). While healthy eating self-efficacy provides an increase in knowledge and behaviors of making healthy food choices, an increase in self-efficacy also increases the possibility of changing and shaping existing habits (13). The school-age period is when the child opens up to the outside world beyond the family, starts making independent decisions, and takes on more responsibility for what and how much to eat (14). Schools or other environments where parents are absent and independent provide opportunities for children to acquire the necessary skills to make healthy decisions about eating decisions (15).

Children who consume healthy foods by preferring low-fat and low-sugar foods have a high level of self-efficacy for healthy eating (12). In the literature, it is emphasized that healthy eating self-efficacy is an important indicator that should be addressed because it is a determinant of eating habits and body mass index values in children. Therefore, it is necessary to evaluate healthy eating and to examine the factors affecting healthy eating self-efficacy (12,15). When the studies were examined, it was found that there were no studies directly examining the effect of family support related to healthy eating on children's healthy eating self-efficacy, but there were studies suggesting that this issue should be emphasized (14,16,17).

Parents play a critical role in the development and maintenance of healthy eating behaviors in children by influencing their dietary preferences and habits (14). Parents' guidance, the types of foods they offer to children,

their feeding behaviors, attitudes and eating behavior models affect children's food choices and play an important role in children's healthy eating self-efficacy (1). Parents' guidance and the types of food they offer to children affect the child's nutritional preferences and habits in the long term (1). Parents shape the home environment and support children's regular nutrition to promote healthy eating behaviors. Actions such as organizing family meals where everyone is together, going to fast-food restaurants less, and shopping more in grocery stores where affordable healthy foods are available constitute an opportunity to develop healthy eating behaviors as well as the foundation of healthy eating habits in adulthood (18,19).

The literature review revealed no studies examining the effect of family support for healthy eating on children's healthy eating self-efficacy, an important factor in shaping their eating behaviors. In this context, the aim of the study was to evaluate the relationship between family support for healthy eating and healthy eating self-efficacy in children.

## MATERIAL AND METHODS

This descriptive and correlational study was conducted to evaluate the relationship between family support for healthy eating and healthy eating self-efficacy in school children aged 8-10 years. The study was conducted between October 2021 and June 2022 with 621 students between the ages of 8 and 10, attending 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> grades in schools selected by simple random sampling method among the primary schools affiliated to the Izmir Provincial Directorate of National Education. The study was conducted only with children in the 8-10 age group because the questionnaire forms used in the study were developed specifically for children in this age range, and students who had just started the first grade of primary school may have difficulty in answering the questions on the scale items on their own. While forming the sample of the study, two districts were included by simple random sampling method (lottery method) among the districts of Izmir province. Among the schools in the two districts, 10 schools were included in the study by simple random sampling method (lottery method). The data of the study were collected by the researchers by giving a questionnaire form to the students in the classroom environment. Both scale forms were filled in by children. The researchers stayed in the classroom during the data collection process due to the possibility of students asking questions. Throughout the data collection process, students at each grade level found both questionnaires understandable.

### Population and Sample of the Study

The required sample size was determined as 330 at a significance level of 0.05, power of 80% and medium effect size obtained from this study by using the results of the comparison of mean scores according to socio-economic level by Kabasakal et al., in the G Power program (18). In order to clearly demonstrate the relationship between the variables and to avoid bias in the study, all children who were willing to participate in the study, who had a written consent form (written parental consent) and who met the inclusion criteria were included in the study and questionnaire forms were applied to a total

of 621 children. The percentage of reaching the sample was 95.5%. A total of 650 students in 10 schools were included in the sample of the study and the questionnaire was distributed, but students with missing data and those who did not complete the questionnaire were not included in the study. The inclusion criteria of the study were that the age range of children was 8-10 years old. The exclusion criteria of the study; are lack of written consent by the parents, the desire to leave the study at any stage of the study, any physical disability and special needs in children, and the use of psychiatric medication.

### Data Collection Tools

In this study, data were collected using the "Descriptive Information Form", "Scale of Family Support Related to Healthy Eating" and "Healthy Eating Self-Efficacy Scale", which were developed by the researchers based on a literature review.

### Descriptive Information Form

The descriptive information form was created by reviewing the literature (10,12,15,18,19). It included questions about the socio-demographic characteristics of the students including age, gender, grade, parental education level and eating preferences.

### The Parental Support for Healthy Eating (PSHE)

The Parental Support for Healthy Eating Scale (PSHE) was developed by Story et al., (21) to assess family support for healthy eating. The scale, the Turkish validity and reliability of which was performed by Kabasakal et al., (18), consists of five items and one sub-dimension similar to the original scale. The scale is evaluated with a minimum score of 5 and a maximum score of 15, with a high score indicating positive family support for healthy eating (18). As a result of the Explanatory Factor Analysis (EFA) of the scale, the percentage of explanation was 56.49%. The Cronbach's alpha coefficient of the scale was above 0.70 and was calculated as 0.74 for boys and 0.80 for girls. The scale is a valid and reliable measurement tool that can be used to assess family support for healthy eating in both boys and girls aged 8-10 years (18). In this study, the total Cronbach alpha value of the scale was found to be 0.85.

### Healthy Eating Self-Efficacy Scale for Children (HESES-C)

The Turkish psychometric properties of the scale developed by Story et al., (20) were examined by Kabasakal et al., (12). The Cronbach's alpha value of the scale was found to be 0.674 for girls and 0.677 for boys. The scale was developed for children aged 8-10 years to be used in the assessment of children's self-efficacy for healthy eating. The scale is a three-point Likert-type scale consisting of nine items and one sub-dimension. An increase in the scale score indicates an increase in self-efficacy for healthy eating (12). The scale is a valid and reliable measurement tool for determining the healthy eating self-efficacy of children aged 8-10 years (12). In

this study, the total Cronbach alpha value of the scale was found to be 0.80.

### Statistical Analysis

Research data were analyzed using SPSS Statistics 25.0 (IBM Corp., Armonk, NY). The demographic data were analyzed using the numbers and percentages. Whether the data fit a normal distribution was analyzed by calculating the kurtosis and skewness coefficients. (Kurtosis and skewness coefficients of data was found between  $\pm 2$ ). The relationship between family support for healthy eating and healthy eating self-efficacy was evaluated by Pearson correlation coefficients, and the effect of family support for healthy eating on healthy eating self-efficacy was evaluated by simple linear regression analysis. Tolerance, VIF (variance inflation factor), and condition index values were used to determine which of the independent variables would be included in the model [to determine the existence of multicollinearity]. Independent variables with a VIF value of  $< 10$ , tolerance value of  $> 0.2$ , and condition index value of  $< 15$  were included in the regression analysis. The significance level of 0.05 was considered acceptable.

### Ethics Committee Approval

Permission to use the scales was obtained via e-mail from the researchers who performed the Turkish validity and reliability of the scales planned to be used in the study. Ethics committee approval was obtained from Dokuz Eylul University Non-Interventional Research Ethics Committee (Date: 22.09.2021, Decision No: 2021/26-39). Institutional permission dated 14.09.2021 and numbered E-12018877- 604.01.02-31890541 was obtained from Izmir Governorship Provincial Directorate of National Education. Children who voluntarily agreed to participate in the study and had a written parental consent form were included. Since individual rights should be protected in the study, the Helsinki Declaration of Human Rights was adhered to during the study.

### RESULTS

This study was conducted with 621 students attending 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> grades selected by simple random sampling method from primary schools affiliated to Izmir Provincial Directorate of National Education. 47% of the students were male (n=292) and when the grade level was analyzed; 3.54% (n=22) were in the second grade, 36.40% (n=226) were in the third grade, and 60.06% (n=373) were in the fourth grade. Descriptive information about children and parents is given in Table 1.

The mean total scores of the children from the scales were found to be  $12.23 \pm 2.10$  and  $12.36 \pm 2.68$ , respectively, for the total mean score of the PSHE scale and the HESES-C (Table 2).

When the correlation between the mean total scores of the family support scale related to healthy eating and the mean total scores of the healthy eating self-efficacy scale was examined, it was determined that there was a positive and moderately significant relationship between the mean total scores of the family support scale related to healthy

**Table 1.** Descriptive information form for children and parents (n=621)

	n	%
<b>Gender of the Child</b>		
Male	292	47
Female	329	53
<b>Age of the Child</b>		
Age of 8	173	27.86
Age of 9	311	50.08
Age of 10	137	22.06
<b>Class of Child</b>		
2 <sup>nd</sup>	22	3.54
3 <sup>st</sup>	226	36.40
4 <sup>th</sup>	373	60.06
<b>Mother's Education Status</b>		
Illiterate	18	2.90
Primary School	129	20.77
Middle School	158	25.44
High School	192	30.92
Undergraduate	112	18.04
Others	12	1.93
<b>Father's Education Status</b>		
Illiterate	7	1.13
Primary School	130	20.94
Middle School	135	21.74
High School	219	35.26
Undergraduate	119	19.16
Others	11	1.77
<b>Availability of breakfast in the morning</b>		
I do it regularly	482	77.61
I do it from time to time	112	18.04
I never have breakfast	27	4.35
<b>Foods commonly eaten for breakfast *</b>		
Egg	343	55.23
Cheese	348	56.04
Olive	420	67.63
Tomato	413	66.51
Cucumber	348	56.04
Pastry-Bagel	420	67.63
Sausage	343	55.23
Bread	348	56.04
<b>Drinks commonly consumed at breakfast</b>		
Milk	242	39.00
Fruit juice	119	19.15
Tea	232	37.35
Buttermilk	28	4.50
<b>Lunchtime eating status</b>		
Regularly	552	88.89
Sometimes	69	11.11
<b>The most common foods brought from home to eat during breaks</b>		
Fresh fruit	344*	55.40
Dried Fruit	88	14.17
Nuts	201*	32.37
Milk	272*	43.80
Buttermilk	213*	34.30
Kefir	51	8.21
Instant Fruit Juice	256*	41.22
Cola-sodas	25	4.02
I won't bring it	32	5.15

\* Each child gave more than one answer.

**Table 2.** Mean total scale scores of children (n=621)

	X	SD
PSHE	12.23	2.10
HESES-C	12.36	2.68

model studied to examine the relationship between children's family support for healthy eating and healthy eating self-efficacy was significant ( $F=194.651$ ,  $p<0.001$ ). As seen in the regression analysis, the family support scale related to healthy eating was a significant predictor of healthy eating self-efficacy ( $\beta=.489$ ,  $p<0.001$ ). The family support scale related to healthy eating variable explained 24% ( $F= 194.651$ ,  $p<0.001$ ) of children's healthy eating self-efficacy (21) (Table 4).

**Table 3.** The correlation between family support for healthy eating and healthy eating self-efficacy in children (n=621)

	1	2
	r	
1. Total Points Average of PSHE	1.0	
2. Total Points Average of HESES-C	0.489*	1.0

\*  $p<0.001$ ; r= Correlation coefficient

**Table 4.** The predictive status of family support related to healthy eating on healthy eating self-efficacy in children (n=621)

	Model 1
	$\beta$
PSHE	0.489*
R	0.239
$R^2$	0.489
F	194.651
SE	1.801
B	14.117
T	20.286
P	<0.001
DW	1.963

DW: Durbin Watson; SE: Standard Error; R: Coefficient of Common Correlation; B: Standardize Beta

## DISCUSSION

Although adequate and balanced nutrition is important for a healthy and quality life in every period of life, the importance of nutrition increases even more in the school age period when growth and development accelerate, and learning and comprehension functions gain importance. In this age group in which physical growth and development accelerate, children's energy and nutrient requirements must be met in an adequate and balanced manner in order to ensure rapid growth and development (22).

The most important issue in the nutrition of school-age children is the acquisition of eating habits within the framework of "healthy eating". Breakfast plays a crucial role in healthy nutrition. Breakfast is the most frequently skipped meal in school-age children (23,24). It was found that 22.3% (n=139) of the children in our study did not eat breakfast regularly.

eating and the mean total scores of the healthy eating self-efficacy scale ( $r=0.489$ ,  $p<0.001$ ) (Table 3).

A model was created by considering the relationships between the study variables and healthy eating self-efficacy. The model was evaluated using simple regression analysis. It was determined that the regression

In a study conducted by Yılmaz et al., (24) with 183 primary school students to examine obesity, physical activity and self-efficacy levels in primary school students, it was found that 60.1% of the students regularly ate breakfast, and the students who skipped breakfast did not eat breakfast because they did not have enough time (47.6%) and did not want to eat breakfast (42.7%) (24). In a study by Oğuzöncül et al., (25) in which the nutritional habits of children aged 6-15 years were examined, it was emphasized that 17.3% (n=30) of the students did not eat breakfast regularly, and when children could not acquire the habit of planning time appropriately for sleeping, resting, playing and working activities, they could not get up on time in the morning and eat breakfast, and thus skipped the breakfast meal (25). Although the literature and study results show that there is still a need for the acquisition of breakfast habits in school-age children, it is thought that breakfast is important in adequate and balanced nutrition of children. It is recommended that children should acquire the habit of eating breakfast and skipping meals should be prevented for adequate and balanced nutrition (23-25).

In this study, it was found that the foods that children most frequently brought from home to eat during recess breaks were mostly healthy snacks; however, the most frequently brought beverages were ready-to-drink fruit juice at a high rate, unhealthy drinks such as cola and soda at a very low rate, and very few children did not bring any food at all. Studies have emphasized that there are many factors affecting children's choice of healthy snacks (environmental, social, cultural factors, etc.), but it is emphasized that parents play a key role especially in the food choice of school-age children, and especially the attitudes of parents in food choice are decisive (26,27). In a study conducted by Yalınkaya et al., (26) to examine the purchasing behaviors of primary school students from canteens, it was found that students frequently bought packaged and unhealthy foods from the canteen during breaks and consumed ready-made fruit juices (27). In a study conducted by Köseadağ et al., (28) to determine the contents of lunch boxes of 74 primary school students, when lunch boxes were examined according to food groups for 20 days, it was found that students did not have a balanced and regular diet and did not take enough from each food group, and that there were mostly carbohydrate-dominant and uniform foods such as toast and pastries in the lunch boxes of the students (28). The fact that the children in our study mostly brought healthy snacks suggests that both children and parents were aware of healthy eating because they had received education on healthy eating before.

The family environment is the most effective environment in which children's eating habits are shaped. Eating behavior is acquired at the family table. The family's approach to food has a direct or indirect effect on children's food choices (29). The positive or negative reaction of the parents to food will cause the child to take that behavior as

a model and repeat it. When parents offer food, they do not like the child in a more limited way, it may cause a reaction against that food in the child, whereas the child may develop sympathy for the foods they like (30). In our study, the mean total score of the Family Support Scale for Healthy Eating was found to be  $12.23 \pm 2.10$  and the mean total score of the Healthy Eating Self-Efficacy Scale was found to be  $12.36 \pm 2.68$ . In addition, it was found that there was a positive and moderately significant relationship between the mean total score of the family support scale related to healthy eating and the mean total score of the healthy eating self-efficacy scale in children, and 24% of the factors affecting children's healthy eating self-efficacy were explained by the mean total score of the family support scale.

Holley et al., (31), it was found that parents of children who chose vegetables and consumed fewer vegetables also consumed fewer vegetables (31). Studies emphasize that it is important for parents to realize how effective they are in helping their children acquire healthy lifestyle behaviors (healthy eating behavior, physical activity, etc.), and that going to the market together to choose healthy snacks and talking about healthy foods with their children are very effective in their children's food choices. For example, parents preparing plates of vegetables and fruits for their children at home during feeding times ensure that children consume healthy snacks instead of junk food. In addition to their children's eating preferences, parents enable children to gain experience in healthy eating by determining consumption patterns and the foods accessible to children (32,33). Many studies in the literature show that there are significant similarities between the foods that parents, especially mothers, dislike and those of the child, and as a result, parents have a great importance in children's eating and nutrition behaviors (34-38). It is thought that parents' healthy eating and drinking behaviors will be effective in children's acquisition of these habits.

Although the findings of our study examining the effect of family support for healthy eating on healthy eating self-efficacy in children are valuable, there are some limitations in the study. The first limitation of the study is that the results obtained are limited to the students included in this study. The last limitation of the study is that due to the limited number of studies on the subject, the discussion section of the study could not be adequately compared with the studies in different sample groups.

## CONCLUSION

As a result of this study, it was found that there was a positive and moderately significant relationship between the mean total scores of the family support scale related to healthy eating and the mean total score of healthy eating self-efficacy in children. Since there is a limited number of studies on this subject, it is thought that the results of this study will shed light on the literature.

It is recommended to plan more comprehensive studies in different sample groups in order to evaluate the effect of family support for healthy eating on healthy eating self-efficacy in children, and to conduct interventional studies on family support for healthy eating and healthy eating self-efficacy in children.

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