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Eating Behaviour & Parental Self-Efficacy Among School-Going Children

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ABSTRACT
Enforcing a healthier lifestyle at the school level helps school-going children change their lives in a better way. Limited studies have been conducted on nutritional status and eating behaviours. The study is to find out the nutritional status among selected school-going children and study their eating behaviour in Coimbatore City. Five hundred school-going children were selected for the study from six schools in the urban areas of Coimbatore District. The nutritional status and eating behaviour were studied among school children using the Eating Attitude Test (EAT-26 scale). 300 boys and 200 girls in the age group of 11-13 years were selected based on the inclusion and exclusion criteria. The anthropometric measurements of height and weight were measured using standard procedures. Body Mass Index (BMI) was determined using WHO standards. The Eating Attitude Test (EAT-26) was applied to study the eating behaviour of children. The Parental Self-Efficacy Questionnaire(PSEQ) and Eating Self-Efficacy Brief Scale (ESEBS) were used to study the parental and eating self-efficacy of children and parents at risk of developing EAT-26. The prevalence of overweight and obesity was 19.6 % and 9.6 %, respectively, among the 500 children. Thinness and severe thinness were 10% and 6.2%, respectively, among the children. Eating behaviour results showed that 36.7% of boys and 45.0% of girls were at risk of developing eating disorders.

Key-words: *Eating Attitude Tests (EAT-26), Dieting, Bulimia and Food Preoccupation, Oral control.*

INTRODUCTION

Nutrition is vital in promoting health and preventing disease, and nutritious food is the primary source of proper growth and development. Nutritional status is a crucial measure of quality of life, particularly for children[(1).] Comprehending children's nutritional status holds significant implications for the optimal development of future generations and societal advancement. Ensuring adequate nutrition during the school years is essential for addressing any deficiencies that may arise during childhood. In India, a significant portion of the population is affected by different types of malnutrition, encompassing macro and micronutrient deficiencies. Healthy nutritional status, mainly healthy weight, is important for school-age children because a nutritional imbalance in school-age children can have profound health implications in their lifetime. According to the World Health Organisation (WHO), the phase of life between childhood is from ages 10 to 19. It is a unique stage of human development and an essential time for laying the foundations of good health. Over 390 million children aged 5-19 years were overweight in 2022, including 160 million who were living with obesity (2024) [(2)]. The consumption of sweets, fast food, sugary beverages, and the excessive addition of salt and sugar to drinks and dishes can lead to the development of unfavourable dietary behaviours and the emergence of adult-onset conditions, including overweight, obesity, diabetes, and cardiovascular diseases [(3)]The Encyclopaedia of Behavioural Medicine offers a comprehensive definition of "Eating Behavior," covering aspects like food choice, motives, feeding practices, dieting, and eating-related issues such as obesity and eating disorders. [(4)]. Eating behaviour plays a significant role in children's diet and food intake, which is an essential determinant of the variation of nutritional status. Some simple parental education and affordable interventions can develop healthy eating habits among children. [(5)]

OBJECTIVE

- To assess the nutritional status among school-going children in Coimbatore.
- To associate the Eating behaviour and parental self-efficacy among school-going children

METHODOLOGY

The sampling technique used for the study was purposive sampling. Five hundred school-going children aged 11 to 13 years were selected from six schools in the urban areas of Coimbatore District. The sample comprised 300 boys and 200 girls, chosen based on specific inclusion and exclusion criteria. Children with special needs were excluded from the study. Necessary permissions were obtained from school authorities to carry out the research, and ethical approval was obtained.

The anthropometric measurements of height and weight were measured using standard procedures for all the selected 500 school-going children. Calculative indices like body mass index (BMI), WHO 2007[6], were determined.

The Eating Attitude Test (EAT-26) (8) was applied to study the eating behaviour of the selected children. Eating Attitude Test (EAT-26) is a screening measure that helps to determine whether one might have an eating disorder that needs professional attention. It is the most widely used measure of eating disorder risk and the presence of disordered eating attitudes. It is an economical first step in screening eating disorders among school children. The fact that most people provide honest responses means that the EAT-26 usually provides very useful information about the eating symptoms and concerns that are common in eating disorders.

It is a non-clinical self-report 26-item measure of individuals' disordered eating attitudes. Questions are presented on a 6-point forced-choice Likert scale ranging from 1 (never) to 6 (always)

Garner, D.M. & Garfinkel, P.E., 1979. The EAT-26 total score ranges from 0 to 78. The EAT-26 scale was segmented into three subscales. 1) Dieting, 2) Bulimia and Food Preoccupation and 3) Oral control. (Garner, Rosen and Berry 1998) [7]

Dieting questions describe the avoidance of high-calorie foods preoccupation with being thinner, while the Food preoccupation questions reflect thoughts about food. In the Oral Control subscale, questions are related to the control of eating and the perceived pressure from others to gain weight.

The 35 questions based on the parental self-efficacy questionnaire were administered to selected parents to study their diet and physical activity and determine their confidence and ability to promote awareness of a healthy diet and physical activity among their children. Their responses were scored on a 5-point Likert scale, ranging from 1 (Not at all confident) to 5 (Extremely confident). Higher scores indicate greater parental self-efficacy in promoting healthy behaviours in children[8].

The Eating Self Efficacy Brief Scale (ESEBS) was used to assess the children's confidence in managing healthy eating habits and food choices.The scale comprises eight items, categorized into two distinct subscales: Emotional Eating Self-Efficacy and Social Eating Self-Efficacy. The Emotional Eating subscale assesses an individual's confidence in resisting the urge to overeat during emotional states such as stress or sadness, while the Social Eating subscale evaluates confidence in managing food intake in social settings, such as parties or gatherings.[9]

The responses were scored each item using a 5-point Likert scale, with response options ranging from 0 (not easy at all) to 5 (extremely confident). Higher scores indicated greater self-efficacy in controlling eating behavior in emotionally or socially challenging situations.

A statistical analysis of the relationship between eating behavior and nutritional status was conducted among children at risk for eating disorders and those not at risk.

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RESULTS AND DISCUSSION

Table 1: Age And Gender of Selected School-Going Children

Gender	11 years		12 years		13 years	
	N=125	%	N=174	%	N=201	%
Boys (N=300)	77	25.6	113	37.7	110	36.7
Girls (N=200)	48	24.0	61	30.5	91	45.5

Among the selected 500 school-going children, 12 and 13 years were found to be high, with 37.7% and 36.7% among boys, and 30.5% and 45.5% of girls, respectively. The selected children were studying 6th to 8th standard.

Table 2. Body Mass Index (BMI) of the selected children

Age (years)		Normal Z score (0)		Thinness Z score (-2SD)		Severe Thinness Z score (-3SD)		Overweight Z score(+1SD)		Obesity Z score(+2SD)	
		N=274	%	N=50	%	N=31	%	N=98	%	N=48	%
11	Boys	41	8.2	2	0.4	9	1.8	17	3.4	8	1.6
	Girls	17	3.4	10	2	5	1	12	2.4	4	0.8
12	Boys	41	8.2	7	1.4	7	1.4	37	7.4	21	4.2
	Girls	39	7.8	13	2.6	2	0.4	5	1	2	0.4
13	Boys	74	14.8	13	2.6	5	1	14	2.8	4	0.8
	Girls	61	12.2	5	1	3	0.6	13	2.6	9	1.8
Total		273	54.6	50	10.0	31	6.2	98	19.6	48	9.6

*WHO Classification 2007

Among the 500 children, 54.6% had a normal body mass index. Overweight was seen among 19.6% (98), while obesity was seen among 9.6 % (48) of the selected children. Thinness and severe thinness were seen among 10% and 6.2% of the selected children, respectively. The prevalence of overweight and obesity was high among boys, which needs to be addressed by primary and secondary methods of prevention.

Table 3: EAT -26 Scores

EAT 26 scores	Reference	Boys (N=300)			Girls (N=200)		
		N	%		N	%	
Prone to Eating Disorders		110	36.7		90	45.0	
Eat 26 Scores		Mean ± SD	Skewness	Kurtosis	Mean ± SD	Skewness	Kurtosis
Prone to Eating Disorders	>20	22±3	0.74	0.51	25±4	0.65	0.53

*Papini et al., 2022 and Babu, S.S. and Aroor, A. R., 2017[10]

Table III illustrates the score obtained by the children using the EAT scale 26. It was found that 36.7 % of boys and 45.0 % of girls were at risk of developing eating disorders. According to (Shashank KJ et al.,2016), 29.2% and 31.09% of subjects exhibited problematic eating attitudes and behaviours among college students [11]. Statistical analysis also showed that the distribution of EAT-26 scores was positively skewed in both groups (Skewness: 0.74 in boys and 0.65 in girls), indicating a majority of respondents had scores below the mean, with a smaller proportion scoring higher. This reflects that while the issue is significant, severe cases are not predominant in the sample. The kurtosis values (0.51 for boys and 0.53 for girls) were close to zero, indicating a distribution that is approximately normal and peaked, suggesting moderate variability around the mean in both groups.

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Table 4: EAT- 26 Subscale Scores

Subscales	Reference	Male			Female		
		Mean ± SD	Skewness	Kurtosis	Mean ± SD	Skewness	Kurtosis
Dieting	0-39	15.0 ±4.28	0.23	0.43	13.1±4.4	0.24	0.45
Bulimia & Food Preoccupation	0-18	4.78 ±3.14	0.31	0.24	4.4±3.56	0.54	0.21
Oral Control	0-21	7.72±3.08	0.07	0.54	8.8±3.49	0.23	0.22

The study revealed that 36.7% of boys (n=110) and 45.0% of girls (n=90) scored above 20 on the EAT-26, indicating a risk for eating disorders. The mean EAT-26 scores were 22 ± 3 for boys and 25 ± 4 for girls, with positive skewness and moderate kurtosis in both groups. This suggests a concentration of scores below the mean with a few higher outliers.

On the dieting subscale, boys had a higher mean score (15.0 ± 4.28) than girls (13.1 ± 4.4), indicating greater concerns about weight and food restriction among males. Bulimia and food preoccupation scores were similar (4.78 ± 3.14 in boys; 4.4 ± 3.56 in girls), showing moderate concern across both genders. In contrast, girls scored higher in oral control (8.8 ± 3.49) than boys (7.72 ± 3.08), reflecting more restraint and control over eating.

Table 5: Comparison of EAT-26 and sub-scales among the selected children

Details	Boys		t-value	p-value	Girls		t-value	p-value
	At Risk N=110	Normal N=110			At Risk N=90	Normal N=90		
Dieting	10.24±4.28	15.02±4.29	4.88	.640^{N}	13.04±4.29	4.31±4.24	-8.90	.718^{Ns}
Bulimia and Food Preoccupation	3.78±3.14	1.53±2.16	-4.37	.000*	4.09±3.56	.97±1.339	-4.83	.000*
Oral Control	7.73±3.064	3.98±3.39	-6.07	.153^{Ns}	8.89±3.49	3.71±3.99	-5.76	.549^{Ns}

***Significant *Ns-Not-Significant**

The comparison of EAT-26 sub-scales Dieting and oral control among school-going children revealed no significant differences between those at risk and those in the normal group for both boys and girls. However, there was a significant difference noted among the at-risk normal boys and girls for Bulimia and Food Preoccupation. Similarly, for girls, the mean Bulimia and Food Preoccupation of 4.09±3.56 was in the at-risk group and .97±1.339 in the normal group, with a significant association ($p < 0.001$).

Table 6 : Comparison of Dieting among at-risk children

Dieting	Boys N = 110		p-value	Girls N=90		p-value
	Positive Responses	Negative Responses		Positive Response	Negative Response	
I am terrified about being overweight.	65	45	000*	56	34	000*
I am aware of the calorie content of foods that I eat.	75	35		48	42	
I particularly avoid foods with high carbohydrate content (i.e. bread, rice, potatoes, etc.).	58	52		25	65	
I feel extremely guilty after eating.	48	62		22	68	
I am occupied with a desire to be thinner.	80	30		29	61	
I think about burning up calories when I exercise.	75	35		55	35	
I am preoccupied with the thought of having fat on my body	65	45		35	55	
I avoid foods with sugar in them.	58	52		56	34	
I eat diet foods.	48	62		36	74	
I feel uncomfortable after eating sweets	38	72		36	75	
I engage in dieting behavior	48	62		25	85	
I like my stomach to be empty	75	32		55	35	

*Significant *Ns-Non-Significant

The dieting sub-scale revealed a significant association between boys and girls related to being overweight, feeling guilty after eating, and engaging in dieting behaviour to prevent obesity. Boys exhibited a desire to be thinner (80) and engage in exercise (75) more than girls(35). Similarly, boys were more conscious of fat deposition, eating diet food, and engaging in dieting behaviour than girls.

Table 7 Comparison of Bulimia and Food Preoccupation among at-risk children

Bulimia and Food Preoccupation	Boys N = 110		p-value	Girls N=90		p-value
	Positive Response	Negative Response		Positive Response	Negative Response	
I find myself preoccupied with food.	35	75	.000*	55	35	.008*
I have gone on eating binges where I feel that I may not be able to stop.	60	50		51	39	
I vomit after I have eaten.	65	45		41	49	
I feel that food controls my life.	50	60		58	32	
I give too much time and thought to food	48	62		56	34	
I have the impulse to vomit after meals.	50	60		40	50	

*Significant *Ns-Non-Significant

Among the at-risk group of school-going children, boys expressed the tendency to be preoccupied with food and food control in their life more than girls. A significant association at a 5% level was noticed among the boys and girls.

Table: Comparison of Oral Control among at At-risk Children

Oral Control	Boys N = 110		p-value	Girls N=90		p-value
	Positive Response	Negative Response		Positive Response	Negative Response	
I avoid eating when I am hungry.	50	60	.023*	35	55	.000*
I cut my food into small pieces.	65	45		39	51	
I feel that others would prefer if I ate more.	48	62		56	34	
Other people think that I am too thin.	58	42		50	40	
I take longer than others to eat my meals.	34	76		35	55	
I display self-control around food.	38	72		36	75	
I feel that others pressure me to eat.	62	48		56	34	

*Significant *Ns-Non-Significant

The results of oral control among the at-risk group pointed out that boys had a greater oral control behaviour, control in their food intake and were very cautious about the amount of food they consumed compared to girls.

Table 9 Comparison of Parental Self-Efficacy (Dietary Behaviour) Questionnaire among children's parents

Dietary Behaviour Questions	Parents of Male children N=110			Parents of Female Children N=90			Chi square	p-value
	Not at all Confident Range of Score	Moderately Confident Range of Score	Highly Confident Range of Score	Not at all Confident Range of Score	Moderately Confident Range of Score	Highly Confident Range of Score		
Cereals	61 ± 5.65	30.3±3.29	18.6±2.35	61.3±0.94	21.6±2.35	7.0±1.4	7.54	0.04
Vegetables	79.8±5.0	12.0±0.0	22.3±2.5	60.9±2.0	20.0±0.0	17.2±8.0	5.56	0.01*
Fruits	59.2±12.7	21.8±9.7	25.1±3.29	34.0±4.49	30.7±4.24	24.3±0.4	7.43	0.02*
Milk Products	62.5±12.6	24.2±10.2	19.0±2.77	58.6±3.41	23.1±2.0	6.9±2.8	2.34	0.12
Sugars	56.7±5.6	32.7±3.5	22.3±0.47	59.6±0.4	21.1±2.6	6.5±2.8	5.45	0.02*
Fats & oils	68.6±10.3	19.7±2.8	18.9±7.5	53.6±0.9	24.3±0.9	12.0±0.0	2.23	0.32
Fast Foods	68.6±10.5	19.8±10.5	18.4±4.9	58.0±3.1	21.8±2.4	9.5±2.6	2.30	1.20

***Significant *Ns-Non-Significant**

Comparison of responses to the Parental Self-Efficacy (Dietary Behaviour) Questionnaire among parents of school-going children revealed a statistically significant difference (p = .05) between fathers and mothers regarding their children's fruit consumption Out of the total 90 parents, 45 fathers and 21 mothers reported lacking confidence that their child consumes two servings of whole fruit or 100% pure fruit juice daily. Similarly, a significant difference was observed concerning low-sodium food intake, with 39 fathers and 19 mothers expressing a lack of confidence in their child's adherence to such dietary choices.

Table 10 Comparison of Parental Self Efficacy(Physical Activity) Questionnaire among children's parents

Physical Activity Questionnaire	Male N=110			Female N=90			Chi Square	Pvalue
	Not at all Confident Range of Score	Moderately Confident Range of Score	Highly Confident Range of Score	Not at all Confident Range of Score	Moderately Confident Range of Score	Highly Confident Range of Score		
28. How confident are you that your child plays outside or is active in sports for a total of at least 60 min on most days of the week?	58	17	35	43	22	25	.958	.619^{Ns}
29. How confident are you that your child is physically active even if the weather is bad?	50	25	35	42	23	25	3.476	.176^{Ns}
30. How confident are you that your child is physically active, even if you have	60	25	25	41	23	26	3.384	.184^{Ns}

excessive demands at work?								
31. How confident are you that your child is physically active, even if there are no gyms, parks or playgrounds nearby	45	15	50	30	25	35	6.008	.050*
32. How confident are you that your child is physically active, even if you are concerned about safety?	25	15	50	41	29	20	0.255	.002*
33. How confident are you that you can limit your child's screen time (i.e. TV, games, computer) to no more than 2 hours per day?	50	25	35	44	21	25	.433	.001*
34. How confident are you that your child is physically active when with friends?	48	25	37	42	21	27	.112	.945^{Ns}
35. How confident are you that your child is physically active, even if they have homework?	38	24	48	33	22	35	2.474	.290^{Ns}

***Significant *Ns-Non-Significant**

A comparison of responses to the Parental Self-Efficacy (Physical Activity) Questionnaire among parents of school-aged children revealed a significant difference ($p < 0.05$) between fathers and mothers. Forty-five out of 110 male and thirty out of 90 mothers reported lacking confidence in their child's ability to remain physically active in the absence of nearby gyms, parks, or playgrounds.

Table 11 Eating Self-Efficacy Brief Scale (ESEBS) Male (N=110)

Social Situations when urge to eat cannot be resisted *	Low self-efficacy	Moderate self-efficacy	High self-efficacy	Chi square	P value

1. When worried about work or studies	17	16	12	16	13	16	8.45	4.23
3. When you feel sad or depressed	11	9	12	8	14	1		
5. When you are very upset and angry	9	1	12	15	11	3		
7. When you are nervous for personal reasons	13	6	7	18	4	7		
Emotional Situations when resistant urge to eat *	**Low self-efficacy**	**Moderate self-efficacy**				**High self-efficacy**	**Chi square**	**P value**
2. When eating outside with friends	10	8	13	9	8	7	8.45	8.45
4. When you are with someone who eats foods that you like	9	6	9	10	11	10		
6. When you are at a party in which there is a buffet full of food	6	11	6	9	12	11		
8. When you are in company and prepare food	9	6	10	16	9	5		

The table examines the relationship between self-efficacy levels (low, moderate, high) and the urge to eat in various emotional and social situations. Self-efficacy here reflects an individual's confidence in resisting the urge to eat under challenging circumstances. In social situations such as being worried about work or studies, the Chi-square value of 8.45 and P-value of 4.23 suggest a statistically significant association between self-efficacy and the urge to eat. Individuals with low self-efficacy tend to struggle more with controlling their eating in stressful situations. Similar trends are visible in emotionally charged situations such as feeling sad, angry, or nervous, though Chi-square and P-values for these were not reported, limiting statistical interpretation. In emotional/social contexts like eating out with friends, the Chi-square value again stands at 8.45, but the P-value (8.45) appears to be misreported or unclear, making interpretation inconclusive. However, across scenarios like being around preferred foods, buffets, or preparing food in company, individuals with higher self-efficacy consistently report fewer urges to eat, reflecting better emotional and behavioural regulation. These findings reinforce the role of self-efficacy in managing emotional and situational eating. Improving self-efficacy through behavioural strategies, stress management, and nutritional education may help individuals resist inappropriate eating urges, especially in high-risk situations.

Table 12 Eating Self-Efficacy Brief Scale (ESEBS) Female (N=90)

Social Situations when urge to eat cannot be resisted *	**Low self-efficacy**	**Moderate self-efficacy**				**High self-efficacy**	**Chi square**	**P value**
1. When you are worried about work or studies	18	13	12	14	12	21	4.34	0.04
3. When you feel sad or depressed	19	18	12	16	12	13		
5. When you are very upset and angry	11	7	15	17	25	15		
7.When you are nervous for personal reasons	16	19	15	8	12	10		
Emotional Situations when resistant urge to eat *	**Low self-efficacy**	**Moderate self-efficacy**				**High self-efficacy**	**Chi square**	**P value**
2.When you eat outside (e.g. restaurant)with friends	17	18	10	22	13	10	5.41	0.023
4. When you are with someone who eats foods that you like	13	20	11	12	16	18		
6. When you are at a party in which there is a buffet full of food	14	18	19	15	14	10		
8. When you are in company and prepare food	20	15	16	15	14	10		

The table 12 shows the association between eating self-efficacy and the urge to eat in emotional and social situations among females (N=90). Significant results were found when participants were worried about work or studies ($p = 0.04$) and eating out with friends ($p = 0.023$), indicating that low self-efficacy is linked to higher eating urges in these situations. In other contexts, like sadness, anger, and buffet settings, no statistical significance was

observed, but those with high self-efficacy generally showed better control. Overall, low self-efficacy increases vulnerability to emotional and social eating. Enhancing self-efficacy could help improve eating behavior in challenging situations.

DISCUSSION

The study found that 18.4% of boys and 17.5% of girls were at risk of developing eating disorders, which can have serious consequences for the overall well-being of school-aged children. Both overweight and obesity were observed among the participants. While 54.8% of the children had a normal body mass index (BMI), 19.6% (n = 98) were classified as overweight, and 9.6% (n = 48) as obese. A comparison of EAT-26 scores and subscale results showed a statistically significant difference between boys and girls ($p < 0.05$). These findings highlight the need for more effective community-level interventions focused on promoting healthy eating and physical activity to prevent underweight, overweight, and obesity among school children.

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