

Investigating Mothers' Decisions to Give Their 2- to 3-Year-Old Child a Nutritionally Balanced Diet

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A psychosocial investigation of Mothers' decisions to give their 2-3 year old child a
nutritionally balanced diet

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Abstract

Objective: To identify, using the Theory of Planned Behaviour, the socio-cognitive factors that influence mothers' decisions toward (a) 'healthy eating' and (b) limiting 'discretionary choices' (e.g. lollies) for their children aged 2-3 years.

Design: A prospective correlational design with a one-week follow-up.

Participants: A total of 197 mothers completed the main survey, with 161 completing the follow-up behaviour measure.

Variables Measured: Phase one assessed intention, attitude, subjective norm, and perceived behavioural control; and two additional variables of parental role construction and group norms. Phase two assessed follow-up behaviour.

Analysis: Hierarchical multiple regressions (changes in R^2) were utilised to predict mothers' intentions and actions for the two target behaviours.

Results: Attitude, subjective norm, and perceived behavioural control predicted intentions; and intentions and perceived behavioural control predicted behaviour for healthy eating and discretionary choices. Parental role construction was a significant predictor of intentions for both target behaviours.

Conclusions and Implications: Results provide support for the application of the Theory of Planned Behaviour in this context, as well as the addition of parental role construction. The findings illustrate the potential importance of developing intervention programs that account for socio-cognitive factors to modify mothers' child feeding practices that have implications for lifelong health outcomes.

Word Count: 200 words

Keywords: nutrition, theory of planned behaviour, mothers, children, maternal feeding behaviour

Introduction

Poor nutrition is associated with negative physical and psychological outcomes in both the short- and long-term (1). The National Health and Medical Research Council (NHRMC; 2) has identified diet as the "...single most important behavioural risk factor that can be improved to have a significant impact on health" (p. 1). Eating patterns established in childhood have been found to endure into adulthood (3). As the number of children developing conditions associated with poor nutrition increases (e.g. diabetes, obesity), so too does the risk of developing chronic health conditions in the future (e.g. cardiovascular disease, certain cancers; 4, 5). The recently revised Australian Dietary Guidelines (2013) recommend consuming a wide variety of foods from the five food groups (healthy eating) and limiting 'discretionary food choices' (e.g. lollies, chips) as part of a healthy lifestyle to promote overall wellbeing (2).

Young children are dependent on their parents, in particular their mother, to provide them with food as they are not yet able to do so independently (6, 7). While young children may have their own food preferences, their mother often has the decision and control over the types of food the child is exposed to (8). Despite this fact, currently there is a dearth of literature examining the role of mothers' decisions on young children's eating habits. A significant amount of research investigating a broad range of behaviours has placed the Theory of Planned Behaviour (TPB; 9) as one of the most influential models of decision making (10, 11). Ajzen (9) proposed that intention is the proximal determinant of behaviour, with intentions governed by attitude (perceived positive/negative valence of performing a behaviour), subjective norm (perceived social pressure by significant others to perform/not perform the behaviour), and perceived behavioural control (PBC; perceived ease/difficulty to perform the behaviour), with PBC further predicting behaviour directly (9, 11). The TPB has been applied to a range of health-related behaviours (e.g. dietary quality, physical activity,

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vitamin supplementation) among parents of young children (12-17); however, few studies have been applied to dietary guidelines including those recently developed by the NHMRC (2, 15).

Given the significance of social influences on parents' decisions, other social factors such as parental role construction and group norms, in addition to the subjective norm construct in the TPB, may be important to consider (18, 19). According to Hoover-Dempsey and Sandler's (20) model of parental involvement, roles reflect the extent to which parents have considered their personal responsibility or accountability, which in turn, guides their actions. These roles are the behavioural expectations and characteristics held by groups or individuals about members of that group (e.g. parents; 20). This parental role encompasses a parent's involvement with their child, and is determined by a parent's definition of their role and beliefs regarding child rearing, child development, and what is expected of a parent (20). Thus, while subjective norm reflects perceived social pressure from significant others (9), parental role construction is the extent to which an individual has internalised socially prescribed role constructions and the internalised meanings and expectations attached to holding a particular kind of role (20). Individuals who internalise this role, its meaning and expectations, are motivated to be involved in their child's welfare and behave in ways that fulfil the parenting role. Therefore, parental role construction, in addition to subject norm, should have a direct, independent influence on a mother's behavioural intentions to provide their child with a nutritionally balanced diet. This construct has received support in both the education and health fields with respect to parental decision making and its addition to the TPB (12, 21, 22).

Group norms refer to the implicit or explicit rules regarding appropriate behaviour, which differs from the subjective norm construct included in the TPB (23). While subjective norms are injunctive norms referring to the perceived social pressure from significant others

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(e.g. family members; 9), group norms reflect perceived membership to behaviourally relevant referent groups (e.g. other mothers; 23). Group norms have been incorporated into TPB-based studies, independently predicting individuals' intentions for a range of health behaviours including using online information to diagnose and treat child health conditions (24), sun-safe practices (25), and drinking and swimming (26). Similarly, a meta-analysis found support for the descriptive norms construct when investigating its contribution within the TPB. Descriptive norms, which incorporates an element of group norms (i.e., what significant others think), provided an additional 5% explanation of variance in behavioural intention (27). In addition, a review of TPB studies incorporating additional variables into the model (e.g., belief salience measures, self-identity) found support for the inclusion of group norms (28). More specifically, a recent TPB study examining mothers' decisions about their child's physical activity and screen-time behaviours showed group norms independently predicted mothers' behavioural intentions (13).

The aim of the current study was to investigate the factors impacting the behavioural intentions and nutritional decisions of mothers for their young child. The current study focused on mothers of a 2-3 year-old, as the literature indicates that although children are becoming more independent in their food choices from approximately the age of two years, they remain dependent on their mothers to provide them with food (8). Additionally, the Australian Dietary Guidelines have recently provided clear nutritional targets for children of this age, which to date have not been adopted to systematically investigate decisions for children's nutritional intake. As per the TPB, it was hypothesised that attitude, subjective norm, and PBC would predict behavioural intentions to provide healthy foods and limit discretionary food choices. With reference to the additional variables, it was predicted that parental role construction and group norms would predict behavioural intentions of each of the target behaviours. Additionally, to examine the TPB, the follow-up questionnaire was

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utilised to examine whether mothers behavioural intentions translated into action. Thus, the current study aimed to examine the intention-behaviour relationship. It was hypothesised that behavioural intentions and PBC would predict healthy eating and discretionary food choice behaviours.

Method

Participants

Participants were comprised of 197 Australian mothers ranging in age from 18 to 46 years, with at least one child aged 2 or 3 years. Of the mothers who completed the main questionnaire, 161 (81.7%) completed the follow-up questionnaire one-week later. Table 1 presents demographic information for the participants.

Design and Procedure

Ethics approval was obtained from the University Human Research Ethics Committee. The study adopted a cross-sectional prospective design with two phases of data collection. In phase one, paper-based and online versions were utilised for the main questionnaire. Based on ratio of independent variables ($N < 50 + 8m$), the minimum sample required would be $50 + (8 \times 5)$ or 90 participants (30). In the second phase, a follow-up phone call was conducted one-week later to assess behaviour from the previous week.

Participants were recruited face-to-face via convenience sampling methods, access to childcare facilities, and one swim school; and on-line via social networking sites (e.g. Facebook; *Australia's Mothers Group*). Mothers completed the main questionnaire in either paper-based ($n = 151$, 76.6%) or online formats ($n = 46$, 23.4%), with no demographic differences observed. The study aimed to utilise a range of data collection sources to ensure the sample included a diverse range of participants (e.g., working and stay-at-home mothers) and was largely representative of the population. The organisations approached by the researchers were given an information package on the study, and upon request the

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questionnaires. Written approval was then provided by each organisation and distribution of the questionnaires was conducted by the researchers. As an incentive to participate, individuals were provided the opportunity to go into a prize draw to win one of three double-pass movie vouchers (valued at \$36AUD each).

Measures

The phase one questionnaire contained standard TPB items as outlined by Ajzen (9; behavioural intention, attitude, subjective norm, PBC), and the additional variables of parental role construction and group norms. In the second phase, the follow-up phone call assessed behaviour over the previous week. Two target behaviours were investigated with each of the items in the survey referring to either ‘ensure that my child eats a wide variety of foods from the five food groups according to the recommended serves’ (healthy eating) or ‘ensure that my child’s consumption of discretionary choices is limited to 0-1 serves’ (discretionary food choices), as detailed in the Australian Dietary Guidelines (2). To aid participants in accurately responding, a table of the relevant guidelines was presented at the beginning of each survey section. This included the recommended number of servings for each food group for children aged 2-3 years, and examples of what constituted ‘one serving’ from each group (e.g. ‘1 piece of medium-sized fruit e.g. apple, banana’). The questionnaires measured behavioural intention and behaviour as dependent variables. The independent variables of the TPB constructs (attitude, subjective norm, and PBC) were measured according to standard TPB procedures (9), with the additional variables of parental role construction and group norms adapted from previous research and worded according to TPB specifications (9). Each item was measured on 7-point Likert scales. For each scale, higher scores indicated more positive responses or agreement with the statement.

Behavioural Intention. Three items measured the strength of behavioural intention to perform the target behaviours (e.g. “I intend to [target behaviour] EVERY DAY in the next

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week”, scored [1] *strongly disagree* to [7] *strongly agree*). The scale was reliable with a Cronbach's alpha of .88 for healthy eating and .92 for discretionary food choices.

Attitude. Attitude towards engaging in the target behaviours was measured by four items utilising 7-point semantic differential scales (“For me to ensure that [target behaviour] EVERY DAY in the next week would be”... e.g. “*bad – good*”, scored [1] to [7]). The scale was reliable with a Cronbach's alpha coefficient of .97 for both healthy eating and discretionary food choices.

Subjective norm. Subjective norm was measured by three items assessing perceived social pressure toward performing the target behaviours (e.g. “Most people who are important to me would approve of me [target behaviour] EVERY DAY in the next week”, scored [1] *strongly disagree* to [7] *strongly agree*). The scale was reliable with a Cronbach's alpha coefficient of .84 for healthy eating and .90 for discretionary food choices.

Perceived behavioural control. PBC was measured by two items assessing the mothers' sense of volitional control and confidence in performing the target behaviours (e.g. “It is mostly up to me whether I [target behaviour] EVERY DAY in the next week”, scored [1] *strongly disagree* to [7] *strongly agree*). The scale showed less internal consistency with significant, albeit low-moderate, correlations of $r = .37, p < .01$ for healthy eating and $r = .50, p < .01$ for discretionary food choices (24).

Parental role construction. Three items adapted by Green and Hoover-Dempsey (31) measured parental role construction - mothers' expectations and beliefs of responsibility for their child's behaviour (e.g. “I believe it is my responsibility as a parent to [target behaviour] EVERY DAY in the next week”, scored [1] *strongly disagree* to [7] *strongly agree*). The measure was reliable with a Cronbach's alpha coefficient of .96 for both healthy eating and discretionary food choices.

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Group norm. An elicitation study of a smaller number of the target population revealed that an appropriate reference group for the target behaviours was ‘other mothers I know’. Group norm was measured by four items developed by Terry and Hogg (23) and assessed the behaviours and attitudes of other important referents in this context (e.g. “How many other mothers do you know with a 2 to 3 year old child who would [target behaviour] EVERY DAY in the next week”, scored [1] *none* to [7] *everyone*). The measure was reliable with a Cronbach's alpha coefficient of .84 for healthy eating and .86 for discretionary food choices.

Reported Behaviour. Three items measured behaviour in the past week (e.g. “In the previous week, to what extent did you [target behaviour] EVERY DAY?”, scored [1] *not at all* to [7] *a large extent*). The measure was reliable with a Cronbach's alpha coefficient of .94 for healthy eating and .96 for discretionary food choices.

Statistical Analyses

Data analyses were conducted using the statistical software SPSS-21. Descriptive analyses were conducted to identify the demographic characteristics of the sample population. To ensure no differences were present between online and paper-based versions of the questionnaire, and pilot, main study and drop out participants, t-tests were conducted on demographic and construct variables. Hierarchical multiple regressions were utilised to predict mothers' behavioural intentions for the two target behaviours of healthy eating and discretionary food choices. For behavioural intentions, and based on the study's hypotheses, the TPB variables of attitude, subjective norm, and PBC were entered in Block 1; and parental role construction and group norms were entered in Block 2. For behaviour, and as hypothesised, a multiple regression was used to test if behavioural intentions and PBC predicted mothers' behaviours over the previous week for the two target behaviours.

Results

A total of 197 mothers ($M_{age} = 34.39$, $SD = 5.65$) participated in the study, with 161 completing follow-up questionnaire. Table 2 presents the means, standard deviations, and bivariate correlations for healthy eating and discretionary food choices. On average, mothers ensured that their child engaged in healthy eating and limited their discretionary food choices to a moderate extent over the 7-day follow-up period, with a mean score of 5.61 and 5.16, respectively (on a 7-point scale). As shown in Table 1, PBC was the strongest correlate of healthy eating behavioural intentions, and the subjective norm scale was the strongest correlate of discretionary food choice behavioural intentions. The strongest behavioural correlates were behavioural intention for healthy eating and PBC for discretionary food choice behaviours.

Healthy Eating

Analyses predicting behavioural intention. The results of the hierarchical multiple regression for behavioural intention are displayed in Table 3. Results indicate that the TPB variables entered in Block 1 accounted for 53% (adjusted $R^2 = .52$) of the variance in behavioural intention, $F(3, 193) = 72.45$, $p < .001$. All TPB variables (attitude, subjective norm, and PBC) contributed significantly to the model. After accounting for the TPB variables, the addition of parental role construction, but not group norms, contributed significantly to the model in Block 2, adding approximately 5% variance, $F_{change}(3, 190) = 7.53$, $p < .001$. In the second model, attitude, subjective norms, PBC, and parental role construction predicted mothers' behavioural intentions.

Analyses predicting behaviour. The results of the multiple regression for healthy eating behaviour revealed both behavioural intention ($\beta = .27$) and PBC ($\beta = .29$) as significant predictors of mothers' behaviour, accounting for 25% (adjusted $R^2 = .24$) of the variance in behaviour, $F(2, 160) = 27.20$, $p < .001$, 95% CI [.14, .37].

Discretionary Food Choices

Analyses predicting behavioural intention. The results of the hierarchical multiple regression for behavioural intention are displayed in Table 3. Results indicate that the TPB variables entered in Block 1 accounted for 48% (adjusted $R^2 = .47$) of the variance in behavioural intention, $F(3, 193) = 58.57, p < .001$. All TPB variables (attitude, subjective norm, and PBC) contributed significantly to the model. After accounting for the TPB variables, the addition of parental role construction, but not group norms, contributed significantly to the model in Block 2, adding approximately 3.5%, $F_{change}(3, 190) = 4.60, p < .01$. In the second model, attitude, subjective norm, PBC, and parental role construction predicted mothers' behavioural intentions.

Analyses predicting behaviour. The results of the multiple regression for discretionary food choice behaviour revealed both behavioural intention ($\beta = .25$) and PBC ($\beta = .38$) as significant predictors of mothers' behaviour, accounting for 29% (adjusted $R^2 = .28$) of the variance in behaviour, $F(2, 160) = 33.00, p < .001, 95\% \text{ CI } [.18, .41]$.

Discussion

The current research, to the best of the authors' knowledge, is among the first to investigate self-reported maternal decision making for their 2-3 year old child's nutritional behaviours using a validated theoretical approach and basing the target behaviours on current Australian dietary guidelines. This investigation is particularly important as a nutritionally balanced diet in childhood is likely to endure throughout life, as well as correlate with other healthy behaviours (e.g., exercise; 32). The findings of the current study provide support for the TPB with the overall model explaining 58% and 50% of the variance in mothers' behavioural intentions for healthy eating and discretionary food choices, respectively. The model also predicted 24% and 28% of the variance in mothers' actions for healthy eating and discretionary food choices, respectively, finding support for the intention-behaviour

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relationship examined by the follow-up questionnaire. Consistent with the specifications of the TPB, for both target behaviours, behavioural intention and PBC predicted behaviour; with attitude, subjective norm, and PBC predicting mothers' behavioural intentions. Parental role construction, but not group norms, was also found to be a significant predictor of behavioural intentions for both target behaviours. These findings demonstrate the importance of psychosocial factors in maternal decision making for children's dietary health and can inform intervention programs targeting healthy eating and discretionary food choice behaviours (12-15).

Attitudes have previously been found to be a consistent predictor of healthy eating behaviours (33), including maternal child-feeding practices (14, 15), with mothers holding favourable attitudes towards providing a wide range of healthy foods and limiting discretionary food choices (34). However, and contrary to previous research (33), attitude was the weakest predictor of mothers' behavioural intentions for healthy eating in the current study, and played a less dominant role for discretionary food choices. This finding is potentially due to a high mean score and low variability in responses for both target behaviours, which may have impacted on the usually dominant role of attitudes in TPB-based studies (35). By comparison, and again contrary to previous evidence, subjective norm was found to be a more influential construct on mothers' behavioural intention for both healthy eating and discretionary food choices (10; 36). Ajzen and Madden (37) contend that the relative strength of subjective norm in predicting behavioural intentions may vary according to the population studied, with researchers suggesting that the differing conceptualisations of normative constructs (e.g. subjective, group) may also vary according to different population groups (28). However, in the current study subjective norm was the dominant normative influence on mothers' behavioural intentions to provide healthy foods and limit discretionary food choices. In a similar international study, the subjective norm component was found to be

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a strong predictor within the TPB, with the authors suggesting that media attention and mothers' perception of social pressure may be influencing their decisions (15).

The influence of PBC on healthy eating behavioural intentions and discretionary food choice behavioural intentions, although significant for both target behaviours, was somewhat mixed. PBC emerged as the strongest and weakest predictor of behavioural intentions, for each target behaviour, respectively. Previous research has found the influence of PBC varies according to the degree to which the behaviour is under an individual's volitional control (9, 11). The findings in the current study indicate the strength of volitional control was lower for discretionary food choices than healthy eating. This may be due to mothers' experiencing less control over their child being provided with unhealthy foods, e.g. by grandparents and other children, although further investigation is required to identify why mothers may believe they have less control over discretionary food choices. On the other hand, a higher degree of perceived volitional control regarding the provision of healthy foods was found, which is not unexpected given that mothers are able to choose the foods provided to their child. While the child ultimately decides what is consumed from the foods provided, mothers are able to choose the selection of healthy foods (8). To continue to support mothers, providing strategies to increase children's willingness to try new foods may be beneficial (e.g. celery with sultanas and peanut butter to make 'ants on a log'; 1).

The current study also focused on the impact of additional factors which may provide further explanation into the decision making of mothers for their child's health, although with mixed results. Parental role construction was considered important to include in the current study due to its recognised strength in explaining parental involvement; a key component of ensuring that young, dependent children receive a nutritionally balanced diet (7, 20). The significance of parental role construction reflects the extent to which mothers have considered their role and responsibilities, thus guiding their decisions to be actively involved

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with their child (20). In addition, mothers must also have the self-efficacy and control over healthy eating and discretionary food choice behaviours for parental role construction to be applied (20). The findings of the current study have shown that parental role construction is an efficacious construct for helping to better understand maternal decision making for their child's nutrition.

Given the body of research supporting the incorporation of group norms within the TPB, it was predicted that this construct would significantly influence mothers' decision making beyond the explanation of the subjective norm construct. In the current study, however, group norm was not a significant predictor of mothers' intentions for these key childhood eating behaviours. For the current sample, perceived social pressure (subjective norm), rather than the implicit or explicit rules regarding appropriate behaviour from a mothers' referent group (group norm), was more influential in their decision making processes (38). This indicates that mothers' perceive greater pressure from significant others who are directly involved in their children's health. Prior research indicates that social influence increases with closer proximity rather than distal contact to the individual (39).

Although the findings in the current study provide a platform on which to build future interventions for these childhood eating behaviours, the results should be interpreted in light of its limitations. First, the results require validation and extension to other primary carers who have been found to play a significant role in a child's healthy development (e.g., fathers, grandparents) and to a broader population of mothers including those in rural areas, single mothers, and those with less education; all factors known to be linked with poorer quality diets (15, 24). Similarly, the difference between those who did and did not choose to participate is unknown. This requires further investigation, as the sample population was relatively homogenous (e.g. married, more highly educated). Social desirability may also have impacted on the results obtained, given that the current study utilised a self-report

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survey as well as a telephone follow-up call. For example, public health campaigns frequently highlight the benefits of a nutritionally balanced diet, which may have influenced participant responses (e.g., reporting more favourable attitudes). Similarly, participant's responses may have been primed by providing knowledge about the Australian Dietary Guidelines (2). In addition, having an overall measure for each of the target behaviours in which all possible practices for healthy eating and discretionary choices are incorporated in the one item for each specific behaviour may also limit the study's findings, as the beliefs and actions of people for each individual behaviour may have varied. It is recommended that future research should look at decomposing the range of healthy eating behaviours so that each can be investigated individually. Future studies investigating these behaviours could utilise a combination of other investigative techniques, such as food diaries and online or paper-based follow-up surveys to reduce the impact of possible demand characteristics. Further, as the follow-up of behaviour was limited to 1-week the likelihood of intention predicting behaviour may be governed by the individual's cognitive decision making processes that strive for consistency in their beliefs. Finally, given the somewhat low to moderate correlations for the PBC scale, findings should be interpreted with caution in this context. Despite these limitations, the current study has the ability to inform the development of a theoretically-based intervention program to increase the quality of mother's child feeding practices.

Implications for Research and Practice

The aim of the current study was to investigate the social cognitive factors influencing the decisions of mothers to provide their young child with healthy foods and limit discretionary food choices. The results of this investigation highlight the key factors (e.g., providing a nutritionally balanced diet as part of their role as a parent) impacting on mothers' nutrition decisions for their young children, and provides potential targets for future

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intervention work in this context. These targets could focus on reinforcing mothers' favourable attitudes and identification of healthy practices as part of their parental role; engaging mothers' social supports; and providing strategies to continue to increase their level of control. Broadly, these findings may be useful in refining public health campaigns aimed at increasing children's health. For example, expanding on the use of the 'Health and Fitness Age Challenge' application by the Queensland Government (40), which utilises PBC by providing 'tips' on how to incorporate more fruit and vegetable consumption (e.g. recipes; 41). Other strategies could include encouraging mothers to introduce new foods slowly, as children may need to be presented with new foods multiple times until they are accepted (1). Encouraging mothers to practice these healthy lifestyle choices is critical to ensuring that children develop healthy lifestyle practices, to avoid the negative and life impacting consequences, such as developing diet related diseases and obesity, leading to living a shorter and poorer quality life.

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Table 1

Demographic Characteristics of Participants

Demographic Characteristic	<i>n</i>	%
Marital Status		
Partnered/Married	188	95.4%
Single	4	2.0%
Divorced	5	2.5%
Highest Education Level		
Junior High School (Year 10)	10	5.1%
Senior High School (Year 12)	22	11.2%
TAFE certificate/diploma	52	26.4%
Undergraduate University Degree	62	31.5%
Postgraduate University Degree	51	25.9%
Employment		
Home duties	55	27.9%
On leave	15	7.6%
Full-time work	22	11.2%
Part-time work	72	36.5%
Casual work	21	10.7%
Student	7	3.5%
Other	5	2.5%
Child Food Allergy		
No allergy	164	83.2%
One or more allergies	33	16.8%

1 Table 2

2 *Means, Standard Deviations, and Bivariate Correlations Between all Variables in the Model^a*

Variable	1	2	3	4	5	6	7	M	SD
1. Intention		.39***	.52***	.65***	.54***	.30***	.45**	5.97	1.04
2. Attitude	.49***		.54***	.19**	.25***	.31***	.14	6.52	.08
3. Subjective Norm	.61***	.44***		.37***	.37***	.36***	.30***	6.08	.93
4. PBC	.56***	.36***	.61***		.43***	.15*	.46***	5.68	1.19
5. Parental Role	.46***	.25***	.38***	.45***		.31***	.33***	6.41	1.07
Construction									
6. Group Norm	.32***	.22**	.46***	.25***	.39***		.30***	5.33	1.22
7. Behaviour	.43***	.33***	.42***	.50***	.29***	.09		5.61	1.28
<i>M</i>	6.08	6.47	5.75	5.91	6.42	5.16	5.73		
<i>SD</i>	1.01	.83	1.12	1.06	.92	1.22	1.21		

3 ^aCorrelations for healthy eating behaviour are above the diagonal; correlations for discretionary choices are below the diagonal. *p<.05, **p<.01,
 4 ***p<.001
 5
 6
 7

1 Table 3

2 *Hierarchical Regression Analysis for Variables Predicting Intention (N = 197)*

Variable	Model 1				Model Summary	Model 2				Model Summary
	B	β	95% CI	sr^2		B	β	95% CI	sr^2	
Healthy Eating										
Attitude	.20	.15*	[.05, .34]	.02		.16	.12*	[.02, .30]	.01	
Subjective Norm	.28	.25***	[.14, .42]	.04		.21	.19**	[.07, .34]	.02	
PBC	.46	.53***	[.37, .55]	.24		.39	.45***	[.30, .48]	.15	
Parental Role Construction						.23	.24***	[.13, .34]	.04	
Group Norm						.05	.06	[-.04, .14]	.00	
R ²					.53 ^a					.58 ^b
F					72.45***					52.68***
ΔR^2										.05
ΔF										11.35***
Discretionary Choices										
Attitude	.29	.24***	[.15, .43]	.05		.28	.23***	[.14, .42]	.04	
Subjective Norm	.31	.34***	[.19, .43]	.07		.28	.32***	[.16, .41]	.05	
PBC	.26	.27***	[.13, .38]	.05		.19	.20**	[.07, .32]	.02	
Parental Role Construction						.29	.20**	[.09, .35]	.03	
Group Norm						-.00	-.00	[-.10, .10]	.00	
R ²					.47 ^a					.51 ^b
F					58.57***					39.25***
ΔR^2										.03
ΔF										5.85**

3 Note: ^a 95% CI [.44, .62], ^b 95% CI [.49, .67], *p<.05, **p<.01, ***p<.001

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