

Association between Health Information Obtained via Social Media and Eating Attitudes: A Descriptive and Correlational Study

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Abstract

Aim: Social media has become an important source of health information, shaping individuals' eating attitudes and behaviours. This study aimed to investigate the potential relationship of seeking health information through social media and eating attitudes.

Method: This descriptive and correlational study was conducted with 316 individuals aged 18 years and above through an online questionnaire. Data were collected using the Sociodemographic Information Form, the Eating Attitudes Test-26, and the Health Information Seeking and Verification Scale in Digital Media. Statistical analyses included descriptive statistics, correlation analysis, the Mann–Whitney U test, the Kruskal–Wallis test, and multiple linear regression analysis.

Results: The findings indicated that women had higher disordered eating scores compared to men, and that increased dieting frequency was associated with more negative eating attitudes. A positive relationship was identified between the implementation of health-related content obtained from social media and eating attitudes, whereas digital verification behaviors were specifically associated with restrictive eating patterns. Regression analysis revealed that only gender and dieting frequency significantly predicted eating attitudes, while digital health information-seeking and the application of social media suggestions were not found to exert a direct significant effect.

Conclusion: The findings suggest that individuals' digital health information-seeking behaviors may exert indirect effects on their eating attitudes. Therefore, when evaluating eating attitudes, health professionals should consider gender, dieting behaviors, and digital media interactions. In addition, comprehensive interventions fostering media literacy and body image awareness should be developed.

Keywords: Health knowledge, social media, eating behavior, attitude, body image.

Özgün Araştırma Makalesi (Original Research Article)

Geliş / Received: 28.09.2025 **Kabul / Accepted:** 30.07.2026

DOI: <https://doi.org/10.38079/igusabder.1792718>

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ETHICAL STATEMENT: Ethical approval was obtained from the KTO Karatay University Non-Pharmaceutical and Non-Medical Device Research Ethics Committee (Date: 08.05.2025; Decision No: 2025/031), and written permissions were secured from the authors of the scales used in the research. Informed consent was obtained from participants at the beginning of the study using the Informed Voluntary Consent Form.

Sosyal Medya Aracılığıyla Elde Edilen Sağlık Bilgilerinin Yeme Tutumları Arasındaki İlişki: Tanımlayıcı ve İlişki Arayıcı Bir Çalışma

Öz

Amaç: Sosyal medya, önemli bir sağlık bilgisi kaynağı haline gelmiş olup bireylerin yeme tutumlarını ve davranışlarını şekillendirmektedir. Bu çalışma, sosyal medya aracılığıyla sağlık bilgisi arama ile yeme tutumları arasındaki potansiyel ilişkiyi araştırmayı amaçlamıştır.

Yöntem: Tanımlayıcı ve ilişki arayıcı desende yürütülen araştırma, 18 yaş ve üzerindeki 316 birey ile çevrimiçi anket yoluyla gerçekleştirilmiştir. Veriler Sosyodemografik Bilgi Formu, Yeme Tutum Testi-26 ve Dijital Ortamlarda Sağlık Bilgisi Arama ve Doğrulama Ölçeği kullanılarak toplanmıştır. Veriler, tanımlayıcı istatistikler, korelasyon analizi, Mann–Whitney U testi, Kruskal–Wallis testi ve çoklu doğrusal regresyon analizi ile değerlendirilmiştir.

Bulgular: Kadınların, erkeklere kıyasla daha yüksek yeme bozukluğu puanlarına sahip olduğu ve diyet yapma sıklığındaki artışın daha olumsuz yeme tutumları ile ilişkili olduğu saptanmıştır. Sosyal medyadan elde edilen sağlık içeriklerini uygulamanın yeme tutumları ile pozitif yönde ilişkili olduğu, dijital doğrulama davranışlarının ise özellikle kısıtlayıcı yeme davranışlarıyla ilişkili olduğu belirlenmiştir. Regresyon analizine göre yalnızca cinsiyet ve diyet yapma sıklığı yeme tutumlarını anlamlı düzeyde yordarken, dijital sağlık bilgisi arama ve sosyal medya önerilerini uygulama doğrudan anlamlı bir etki göstermemiştir.

Sonuç: Bulgular, bireylerin dijital sağlık bilgisi arama davranışlarının yeme tutumları üzerinde dolaylı etkiler oluşturabileceğini göstermektedir. Bu doğrultuda sağlık profesyonelleri, yeme tutumlarını değerlendirirken cinsiyet, diyet yapma davranışları ve dijital medya etkileşimlerini dikkate almalı; medya okuryazarlığını ve beden algısı farkındalığını geliştirmeye yönelik kapsamlı müdahaleler geliştirmelidir.

Anahtar Sözcükler: Sağlık bilgisi, sosyal medya, yeme davranışı, tutum, beden algısı.

Introduction

Individuals' eating attitudes are increasingly shaped by online content as digital platforms become major sources of health information. In this process, individuals obtain information not only through traditional media tools but also via the internet and social media platforms¹. This transformation has made digital platforms an important source of information, particularly in areas such as health, nutrition, and lifestyle, which directly affect individuals' daily lives^{2,3}. Indeed, studies indicate that people use social media networks extensively to obtain information on nutrition and health, and that such use has been increasing day by day⁴⁻⁶.

Social media not only serves as a tool for individuals to obtain information about nutrition and health but also plays an active role in shaping attitudes and behaviors. Content shared on these platforms can directly influence individuals' dietary preferences, food choices, and overall eating habits⁷. The dissemination of diet recommendations and popular nutrition trends by social media content creators significantly affects individuals' food selections^{2,8}. When accurate and reliable information is shared, social media can also contribute to enhancing individuals' awareness of healthy eating⁹. In this context, social media is considered to function as a stimulus that encourages individuals to adopt healthier eating habits. Indeed, a study by

Sipahi and Demirel reported that individuals increased their water consumption and reduced their intake of processed foods as a result of exposure to nutrition-related posts on social media¹⁰. On the other hand, it has also been emphasized that incorrect or incomplete information on social media can have negative effects on individuals' eating attitudes and behaviors¹¹. International studies have reported that social media use is associated with unhealthy eating habits among young people, such as skipping breakfast, consuming junk food, and preferring unhealthy foods. Similarly, a systematic review concluded that the time spent on social media is linked to eating disorders¹². Based on these findings, it can be stated that health-related information on social media may influence individuals' eating attitudes and behaviors both positively and negatively. These results highlight the need for updated research on this topic.

Building on this background, the present study was conducted to examine the impact of obtaining information via social media on individuals' eating attitudes and behaviors. Although previous studies have explored the relationship between social media use and dietary behaviors, there remains a need for more comprehensive evidence focusing specifically on how health information obtained through these platforms shapes eating attitudes. This is particularly important given the dual nature of social media as both a source of accurate health information and a channel for misinformation. By addressing this gap, the findings are expected to contribute to the literature by offering evidence that may guide healthcare professionals in developing effective interventions to improve health literacy and promote healthy eating behaviors. This study aimed to investigate the relationship of seeking health information through social media and eating attitudes.

Material and Methods

Design

This study was designed as a descriptive and correlational research.

Variables and Research Questions

In line with the aim of the study, the dependent variable was the mean total score of the Eating Attitudes Test-26 (EAT-26), while the independent variables included participants' sociodemographic characteristics and the mean total score of the Health Information Seeking and Verification Scale in Digital Environments.

Research Questions

- What are individuals' levels of health information seeking and verification in digital environments?
- What are individuals' levels of eating attitudes?
- Is there a significant relationship between individuals' health information seeking and verification in digital environments and their eating attitudes?

- Do individuals' health information seeking and verification levels in digital environments affect their eating attitudes?

Population and Sample

The population of the study consisted of individuals aged 18 years and older. The sample size was calculated based on the correlation coefficient reported for the Eating Attitudes Scale in a study by Koç Özkan et al. ($r=0.18$; $p=0.004$), using 90% statistical power and an effect size of 0.30, resulting in a minimum sample of 316 participants¹³. Accordingly, the data collection process was concluded once the target sample size was reached. A non-probability sampling method, specifically convenience sampling, was used to select participants for the study.

Inclusion and Exclusion Criteria

Individuals aged 18 years and older who were able to speak, read, and write Turkish, had at least one active social media account (*Instagram, Whatsapp, Facebook etc.*) in the past three months, and voluntarily agreed to participate in the study were included. Individuals who did not provide voluntary consent were excluded from the study.

Data Collection Instruments

During the data collection process, the Sociodemographic Information Form, the Health Information Seeking and Verification Scale in Digital Environments, and the Short Form of the Eating Attitudes Test (EAT-26) were used.

The sociodemographic information form: The form was developed based on the literature and includes 16 items designed to determine participants' sociodemographic characteristics as well as social media and eating habits^{2-4,8,10}. The form collected information on age, gender, marital status, educational level, economic status, height, weight, perceived general health status, history of previous eating disorder diagnosis, frequency of dieting, consulting a dietitian or nutritionist, number of daily meals, daily social media usage, social media platforms used for accessing health and nutrition information, trusted social media content, the level of trust in health information on social media, and the extent to which nutrition-related recommendations on social media were implemented.

The health information seeking and verification scale in digital environments: The form was developed by Çömlekçi and Bozkanat to evaluate individuals' behaviors in seeking health information from digital platforms and verifying this information¹⁴. The scale is a 10-item, 5-point Likert-type instrument whose validity and reliability have been tested. It consists of three subdimensions:

- ***Digital verification (Items 7–10):*** Measures participants' habits of verifying health information obtained from digital sources. Higher scores indicate more frequent verification behavior.

- **Web 1.0 and health information seeking (Items 1–3):** Reflects the level of health information acquisition from non-interactive sources (e.g., static websites).
- **Web 2.0 and digital health information seeking (Items 4–6):** Indicates the tendency to seek health information via social media platforms (e.g., Instagram, YouTube, Twitter).

Scores for each subdimension range from 1 to 5. There are no reverse-scored items on the scale. Subdimensions should be evaluated separately; analyzing all items together as a single total score is not recommended. The Cronbach's alpha reliability coefficient of the scale was 0.75 in the original study and 0.73 in the present study.

Short form of the eating attitudes test (EAT-26): EAT-26 is the Turkish adaptation of the Eating Attitudes Test developed by Garner et al. to assess individuals' eating behaviors, attitudes toward eating, and risk of eating disorders¹⁵. The Turkish version was adapted by Ergüney-Okumuş and Sertel-Berk¹⁶. The scale consists of 26 items and is structured as a 6-point Likert-type instrument. The first 25 items are scored from "Always = 3" to "Never = 0," while the 26th item is reverse-coded. The scale includes three subdimensions: *Restrictive Eating* (Items 5, 6, 7, 16, 17, 19, 23), *Eating Preoccupation* (Items 1, 2, 3, 4, 10, 11, 12, 14, 18, 21, 22), and *Social Pressure* (Items 8, 13, 15, 20). In the adaptation study, Items 9, 24, 25, and 26 were not included in any subdimension due to factor loadings and item analysis results. Total scores are calculated from all items, with a cutoff score of 20. Higher scores indicate a greater risk of disordered eating behaviors. Cronbach's alpha reliability coefficient of the scale was 0.84 in the original adaptation study and 0.79 in the present study.

Data Collection Procedure

In order to contribute to environmental sustainability, the data collection process was conducted entirely online. Accordingly, the instruments used in this study were adapted to an online survey format, and participants' responses were collected via Google Forms between May and June 2025. This approach aimed to reduce paper usage and contribute to lowering the carbon footprint. Prior to the main data collection, a pilot study was conducted with a group of 10 participants to test the clarity of the survey, its technical functionality, and the usability of the instruments. Based on the feedback obtained from the pilot study, no modifications were deemed necessary for the survey form. Data obtained from the pilot study were not included in the main analysis. The data collection continued until the predetermined sample size (316 participants) was reached. Once the minimum required number of participants was achieved, access to the survey was restricted to prevent additional responses, thereby ensuring systematic and controlled data collection.

Ethical Statement

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2025/031), and written permissions were secured from the authors of the scales used in the research. Informed consent was obtained from participants at the beginning of the study using the Informed Voluntary Consent Form.

Data Analysis

IBM SPSS 25 software was used for the analysis of the study data. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were calculated to summarize the data. The normality of the data was assessed using the Kolmogorov–Smirnov test and Q-Q plots. The results indicated that the data for the scale score averages did not conform to a normal distribution. Therefore, the Mann–Whitney U test was used for comparisons between two groups, and the Kruskal–Wallis test was applied for comparisons among three or more groups. Relationships between age and body mass index (BMI) and the levels of eating attitudes and digital health information seeking and verification were evaluated using Spearman correlation analysis, taking into account the non-normal distribution of the data. Additionally, multiple regression analysis was conducted to examine the effects of sociodemographic variables and digital health information seeking and verification on eating attitude levels. A 95% confidence interval and a significance level of $p < 0.05$ were used for all analyses.

Results

The findings are presented in line with the study objectives, covering participants' sociodemographic characteristics, levels of digital health information seeking and verification, eating attitudes, and the relationships between these variables. Statistical analyses were conducted to examine differences and associations, and the results are summarized across four tables.

Table 1. Distribution of the mean total scores obtained from the EAT-26 according to some sociodemographic characteristics of the participants (n=316)

	Mean±SD			Min-Max	Test value p
Age	27.56±9.71			18-72	r: 0.038 p: 0.505
BMI (kg/m²)	24.23±4.55			15.96-43.75	r: 0.138 p: 0.014*
	n	%	Mean Rank	EAT-26 Total Score Mean±SD	Test value p
Gender					
Female	255	80.7	166.83	8.93±6.87	Z: -3.324
Male	61	19.3	123.66	5.90±4.25	p: 0.001**
Marital Status					
Married	98	31.0	162.69	8.78±6.99	Z: -0.549
Single	218	69.0	156.61	8.15±6.35	p: 0.583
Educational Status					
Primary school	27	8.5	171.57	9.15±7.07	KW: 0.744
High school	59	18.7	153.37	8.15±6.65	p: 0.689
University or higher	230	72.8	158.28	8.30±6.49	
Perceived Income					
Low	50	15.8	154.59	8.10±6.53	KW: 0.412

Moderate	245	77.5	160.13	8.42±6.55	p: 0.814
High	21	6.6	148.74	8.10±6.87	
Perceived General Health					
Poor	26	8.2	180.42	9.15±5.66	KW: 1.734
Fair	143	45.3	158.20	8.62±7.38	p: 0.420
Good	147	46.5	154.92	7.93±5.82	
Chronic Illness					
Yes	96	30.4	160.79	8.60±7.08	Z: -0.295
No	220	69.6	157.50	8.23±6.32	p: 0.768
Eating Disorder Diagnosis					
Yes	20	6.3	193.80	11.30±8.09	Z: -1.790
No	296	93.7	156.11	8.15±6.40	p: 0.073
Dieting Frequency					
Never	116	36.7	132.58	6.47±4.86	KW: 43.634
Occasionally	157	49.7	156.68	8.15±6.48	p: 0.000**
Frequently	29	9.2	216.12	12.17±7.07	
Continuously	14	4.4	274.25	18.21±6.97	
Receiving Professional Support					
Yes	101	32.0	181.07	10.14±7.89	Z: -3.018
No	215	68.0	147.90	7.50±5.64	p: 0.003**
Daily Meals					
1	7	2.2	167.71	9.00±6.58	KW: 3.702
2	144	45.6	167.70	8.68±6.11	p: 0.296
3	154	48.7	148.44	7.89±6.90	
4 or more	11	3.5	173.14	9.91±7.43	
Daily Social Media Use					
Less than 1 hour	24	7.6	166.38	8.54±6.12	KW: 1.549
1-3 hours	132	41.8	153.87	7.72±5.43	p: 0.671
4-6 hours	118	37.3	157.08	8.43±6.89	
6 hours or more	42	13.3	172.56	9.95±8.65	
Most Frequently Used Health/Nutrition Information Platform					
Instagram	196	62.0	155.09	8.24±6.78	KW: 1.703
Youtube	21	6.6	167.33	8.57±5.60	p: 0.945
Tiktok	8	0.6	156.94	6.88±2.74	
Twitter	5	0.3	151.50	7.00±3.67	
Facebook	4	0.3	177.00	10.25±8.99	
Whatsapp	47	19.0	171.48	9.60±7.73	
Other	35	11.1	154.11	7.43±4.51	
Trusted Content Sources					
Expert posts	262	82.9	157.79	8.32±6.59	KW: 4.095
Influencers	10	3.2	177.20	10.80±9.93	p: 0.536
Blog articles	4	1.3	102.63	5.00±5.59	
Academic articles	19	6.0	182.34	9.53±5.89	
Friends' recommendations	8	2.5	128.75	6.00±3.92	
Other	13	4.1	159.12	7.62±4.77	
Level of Trust					
Do not trust at all	27	8.5	157.52	7.41±4.22	KW: 0.147
Do not trust	58	18.4	155.51	7.93±5.95	p: 0.997
Neutral	175	55.4	159.11	8.30±6.38	
Trust	44	13.9	158.66	9.30±8.52	
Strongly trust	12	3.8	165.63	9.58±8.18	
Applying Social Media Recommendations					
Yes	93	29.4	180.61	9.88±7.15	Z: -2.786
No	223	70.6	149.28	7.70±6.19	p: 0.005**

BMI: body mass index, Z: Mann-Whitney U test, KW: Kruskal Wallis test, r: Spearman correlation test, SD: standard deviation, *:p<0.05; **:p<0.01.

The mean age of the participants was 27.56 ± 9.71 years, and the mean BMI was 24.23 ± 4.55 . The majority were female (80.7%), single (69%), and had a university or higher education level (72.8%). Most reported a moderate income level (77.5%) and perceived their general health as good (46.5%). The majority did not have any chronic illness (69.6%) or an eating disorder diagnosis (93.7%). About half of the participants (49.7%) reported dieting occasionally, 68% had not received support from a dietitian or nutritionist, and 48.7% consumed three meals per day. Daily social media use was 1–3 hours for 41.8% of participants, and 62% frequently obtained health and nutrition information from Instagram. Most participants trusted expert posts on health and nutrition (82.9%), 55.4% were undecided about the reliability of health information on social media, and 70.6% did not apply the diet or nutrition recommendations seen on social media (Table 1).

When EAT-26 total scores were examined according to participants' sociodemographic characteristics, significant differences were observed for gender, dieting frequency, professional support, and adherence to social media recommendations ($p < 0.05$). No significant differences were found for age, marital status, education level, perceived income, perceived general health, presence of illness or eating disorder diagnosis, number of daily meals, daily social media use, or preferred health information platform ($p > 0.05$). Correlation analysis indicated no significant relationship between age and EAT-26 total scores ($r = 0.038$; $p = 0.505$), while a weak positive significant correlation was found with BMI ($r = 0.138$; $p = 0.014$) (Table 1).

Table 2. Mean Scores of Participants on the EAT-26 and the Digital Health Information Seeking and Verification Scale, Total and Subdimensions (n=316)

	Number of Items (Min-Max)	Mean $\pm$ SD
Eating Attitudes Test-Short Form Total Score Mean	26 (0-44)	8.34$\pm$6.55
Restrictive Eating	7 (0-14)	1.93 $\pm$ 2.38
Eating Preoccupation	11 (0-20)	3.75 $\pm$ 4.37
Social Pressure	4 (0-8)	1.16 $\pm$ 1.69
Health Information Seeking and Verification Scale		
Digital Verification	4 (4-20)	11.75 $\pm$ 4.19
Web 1.0 Health Information Seeking	3 (3-14)	7.36 $\pm$ 2.42
Web 2.0/Digital Health Information Seeking	3 (3-15)	7.43 $\pm$ 2.66

The mean total score of EAT-26 was 8.34 ± 6.55 . Mean scores for the subscales were as follows: Restrictive Eating 1.93 ± 2.38 , Eating Preoccupation 3.75 ± 4.37 , and Social Pressure 1.16 ± 1.69 . For the Health Information Seeking and Verification Scale, mean scores were: Digital Verification 11.75 ± 4.19 , Web 1.0 Health Information Seeking 7.36 ± 2.42 , and Web 2.0/Digital Health Information Seeking 7.43 ± 2.66 (Table 2).

Table 3. The relationship between participants' EAT-26 total and subscale mean scores and the Digital Health Information Acquisition and Verification Scale subscale mean scores (n=316)

		EAT-26 Total	Restrictive Eating	Eating Preoccupati on	Social Pressu re	Digital Verificati on	Web 1.0	We b 2.0
EAT-26 Total	r	1.000						
	p							
Restrictive Eating	r	0.609	1.000					
	p	0.000**						
Eating Preoccupati on	r	0.747	0.181	1.000				
	p	0.000**	0.001**					
Social Pressure	r	0.447	0.295	0.112	1.000			
	p	0.000**	0.000**	0.046*				
Digital Verification	r	0.064	0.186	-0.052	0.032	1.000		
	p	0.255	0.001**	0.357	0.570			
Web 1.0	r	0.060	0.017	0.102	0.056	0.257	1.000	
	p	0.287	0.758	0.070	0.324	0.000**		
Web 2.0	r	0.093	0.080	0.129	0.044	0.092	0.433	1.000
	p	0.098	0.154	0.022*	0.435	0.101	0.000**	

r: Spearman correlation test, *:p<0.05; **:p<0.01.

No significant correlation was found between the EAT-26 total score and the subscales of Digital Verification, Web 1.0 Health Information Seeking, and Web 2.0/Digital Health Information Seeking ($p>0.05$). However, a weak positive correlation was observed between the Restrictive Eating subscale and Digital Verification ($r=0.186$; $p=0.001$), as well as between the Eating Preoccupation subscale and Web 2.0/Digital Health Information Seeking ($r=0.129$; $p=0.022$) (Table 3).

Table 4. Effects of Digital Verification, Web 1.0, Web 2.0 Use, and sociodemographic variables on the total score of the EAT-26 ($n=316$)

Eating Attitude Level	B	Std. Error	Z B	t	p	%95 Confidence Interval for β	
Eating Attitude						Lower Limit	Upper Limit
Model							
(Constant)	0.884	3.766		0.235	0.815	-6.527	8.294
Digital Verification	0.042	0.085	0.027	0.495	0.621	-0.125	0.209
Web 1.0	0.153	0.165	0.057	0.925	0.356	-0.172	0.477
Web 2.0	0.241	0.145	0.098	1.657	0.098	-0.045	0.527
BMI	0.095	0.086	0.066	1.097	0.274	-0.075	0.265
Age	-2.227	0.951	-0.134	-2.341	0.020	-4.099	-0.355
Dieting Frequency	2.758	0.504	0.327	5.477	0.000	1.767	3.749
Professional Support	-0.010	0.848	-0.001	-0.012	0.991	-1.679	1.659
Applying Social Media Recommendations	-0.337	0.814	-0.023	-0.414	0.679	-1.938	1.265

Model Significance $F=8.737$; $p=0.00$; $R^2=0.185$; Adjusted $R^2=0.164$, BMI: body mass index, β : Regression coefficient, Se: Standard error, $z\beta$: Standardized regression coefficient, R^2 : Coefficient of determination. ($p<0.05$).

The multiple linear regression model examining factors affecting the EAT-26 total score was statistically significant and met the assumptions of regression analysis ($F=8.737$; $p<0.001$). Among the variables included, only gender and dieting were significant predictors of eating attitudes ($p<0.05$). Digital Verification, Web 1.0, Web 2.0, BMI, professional support, and adherence to social media recommendations were not significant predictors ($p>0.05$). The model explained 18% of the variance in EAT-26 total scores ($R^2=0.185$). Specifically, a one-unit increase in gender (female=1, male=2) was associated with a 2.227-point decrease in eating attitude scores, while a one-unit increase in dieting frequency corresponded to a 2.758-point increase (Table 4).

Discussion

The findings indicate that digital information-seeking, gender, dieting frequency, and social media use are associated with eating attitudes. One of the most notable findings is that female participants exhibited significantly higher disordered eating scores compared to male participants. This finding highlights the potential role of gender-related sociocultural factors in body image and eating behaviors. Social pressures on women to maintain a slimmer and thinner body can lead to stricter, more restrictive, and controlling eating behaviors¹⁷. Previous studies have also indicated that women experience greater body image concerns than men, which in turn negatively affect their eating attitudes^{18,19}. Furthermore, the higher prevalence of psychiatric comorbidities among women suggests that eating disorder psychopathology should be examined from a gender-based perspective. Lydecker and Grilo reported that female participants exhibited significantly higher levels of eating disorder symptoms and depressive symptoms compared to males²⁰. These findings underscore the need to investigate women's eating attitudes within the context of mental health.

Another key finding of the study is the significant positive relationship between dieting frequency and eating attitudes. As the frequency of dieting increased, participants' eating attitude scores also increased. This suggests that dieting practices may be associated with not only for physical health but also for psychological well-being and eating behaviors. This finding aligns with previous studies conducted in clinical samples, which reported that certain dieting practices are associated with eating disorder psychopathology²¹⁻²³. Fan et al. specifically noted that vegetarian and paleo diets may increase the risk of eating disorders in relation to body image and sociocultural ideals of the body²³. In this context, dieting behaviors intensified by social pressures may be associated with negative eating attitudes.

The study findings also indicate that diet- and health-related content on social media platforms can influence individuals' eating attitudes. Participants who applied the recommendations encountered on social media exhibited higher disordered eating scores, suggesting that social media can directly shape eating behaviors. Previous studies similarly report that exposure to social media content—particularly those related to weight loss, ideal body, and dieting—increases body dissatisfaction and the risk of eating disorders²⁴⁻²⁶. Sanzari et al. demonstrated that such content is associated with lower body appreciation, negative appearance evaluation, and binge eating behaviors²⁴. Similarly, Kim and Mackert reported a significant association between social media use and binge eating²⁷. These findings suggest that individuals tend to apply digital content without critical evaluation, which may trigger unhealthy eating behaviors. Therefore, there is a need for intervention studies focused on eating behaviors that consider body image, social pressure, and digital media factors in an integrated manner.

Another notable finding is the positive relationship between restrictive eating behaviors and the tendency to digitally verify information. Participants' inclination to verify the accuracy of information in digital environments appears to be associated with more controlled and restrictive attitudes toward eating. This tendency may be linked to

increased monitoring of eating behaviors when individuals experience body dissatisfaction. Zaharia and Gonça suggest that this behavior could be related to efforts to reduce the discrepancy between one's actual and ideal body²⁸. Moreover, several studies have highlighted that beauty standards promoted on social media negatively affect body image, trigger eating disorder symptoms, and increase the need for interventions that support positive body image^{28,29}.

The findings from the regression analysis revealed that only gender and dieting frequency significantly predicted eating attitudes. In contrast, variables such as digital health information-seeking behavior, adherence to social media recommendations, and the tendency to verify information digitally did not emerge as significant predictors. This suggests that the impact of social media-related behaviors on eating attitudes may occur indirectly rather than directly. This finding is consistent with and supports previous research proposing that psychological factors such as body image, self-esteem, and social comparison may mediate the relationship between social media use and eating attitudes.

The multiple linear regression model was statistically significant and explained 18% of the variance in EAT-26 scores. Only gender and dieting frequency emerged as significant predictors, with higher scores observed among females and those with more frequent dieting. Other variables, including social media-related behaviors, were not significant predictors. Notably, although social media-related variables were not directly associated with eating attitudes in the regression model, their role should not be disregarded. These findings suggest that the relationship between social media use and eating attitudes may not be direct but could operate through indirect pathways involving psychological and behavioral factors. In line with previous research, variables such as body image, self-esteem, and social comparison may play a mediating role in this relationship. However, since such variables were not included in the present study and mediation analysis was not conducted, this interpretation should be considered cautiously and warrants further investigation in future research.

In general, the findings highlight the need for health professionals to develop awareness regarding how individuals evaluate information and recommendations encountered on social media. Critically assessing social media-based content that may influence eating attitudes can support individuals in managing their dietary behaviors more healthily. Furthermore, nutrition counselling is recommended to adopt a multidisciplinary approach that addresses not only physical health but also psychological well-being, body image, and digital media use habits.

In this context, implementing targeted interventions aimed at enhancing media literacy and promoting body positivity may contribute to reducing the risk of eating disorders²⁶.

Limitations and Strengths

This study has several limitations. First, the data were collected via an online platform using self-report measures, which may have introduced bias, as participants may have reported their eating attitudes, social media use, and digital health information-seeking

behaviors differently from their actual practices. Second, the cross-sectional design limits the ability to establish causal relationships between variables; therefore, the findings should be interpreted at a correlational level, and longitudinal studies are needed to better understand these relationships.

Third, the predominance of young adults in the sample restricts the generalizability of the findings to other age groups. Additionally, as the sample consisted of community-dwelling individuals without clinical diagnoses, the results cannot be directly generalized to clinical populations with diagnosed eating disorders.

Another important limitation is that social media use was assessed in a relatively limited manner, primarily in terms of general usage and behaviors. Variables such as the type of content consumed, purpose of use, and level of engagement were not examined, which may be important in understanding the relationship between social media and eating attitudes.

Furthermore, key psychological variables—such as body image, self-esteem, social comparison, and depression—were not included in the study. The absence of these variables limits a more comprehensive understanding of the mechanisms underlying the relationship between social media use and eating attitudes.

Despite these limitations, the study also has several strengths. It contributes to the literature by examining the association between digital health information-seeking via social media and eating attitudes from a multidimensional perspective. The use of psychometrically valid and reliable scales strengthens the internal validity of the findings. Additionally, the study highlights the possibility that the relationship between social media use and eating attitudes may operate through indirect pathways, providing a basis for future research, including studies using mediation models.

Conclusion

The findings indicate that digital information-seeking, gender, dieting frequency, and social media use are associated with eating attitudes. Women exhibited higher levels of problematic eating attitudes, highlighting the influence of societal pressures on body image, while frequent dieting was associated with an increased risk of disordered eating. Although following nutrition recommendations on social media and digital verification behaviors were not identified as direct predictors, these factors may still have indirect influences on eating attitudes.

These findings suggest that eating attitudes in the digital age are shaped not only by individual behaviors but also by broader psychosocial and digital factors. Therefore, healthcare professionals should consider these dimensions when evaluating dietary behaviors. In addition, interventions aimed at improving media literacy and promoting critical evaluation of online health information may help prevent negative eating outcomes. Future studies should incorporate psychological variables such as body image and self-esteem to better understand these relationships.

Ethical Compliance

Prior to initiating the study, ethical approval was obtained from the KTO Karatay University Non-Pharmaceutical and Non-Medical Device Research Ethics Committee (Date: 08.05.2025; Decision No.: 2025/031), and written permissions were secured from the authors of the scales used in the research. Informed consent was obtained from participants at the beginning of the study using the Informed Voluntary Consent Form. Participants were provided with detailed information about the study's purpose and the intended use of the data. Additionally, in accordance with the Declaration of Helsinki, ethical principles including "Respect for Human Dignity," "Respect for Autonomy," and "Confidentiality and Privacy Protection" were applied. This ensured that participants' ethical rights and safety were safeguarded and that the research process was conducted meticulously.

Conflict of Interest Statement

The authors declare no conflict of interest.

Funding

No financial support was received for this study.

Data Availability

Data will be made available upon request.

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