FAMILY DECISION-MAKING DURING FOOD BUYING

VOLUME 2

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Family conflicts and conflict resolution regarding food choices

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Maria Kümpel Nørgaard’s research interests focus on consumer behaviour and food from a family perspective. Her research covers family decision-making in food buying and consumption, children’s influence, children’s consumer socialisation, children’s own decision-making and food-related health aspects.

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Family conflicts and conflict resolution regarding food choices

Abstract

Previous studies on family decision-making show that parents, but also children participate actively in and achieve influence on the decision process, for instance during food buying. When decision-making includes several active participants conflicts may occur, but not much research deals with family decision-making, conflicts, conflict resolutions or the influence process itself. This article focuses on parents and tweens’ joint decision processes in evaluation and choice of food, specifically conflicts and conflict resolution. Assumptions are explored in an empirical study of Danish families with children. The main results show that during food buying family communication is open for opinion statements and discussions between parents and their tweens. However, not everything is that overt in family communication. One of the most interesting findings and a new insight is tweens’ use of the help technique with the aim of easing family life. It is unclear whether parents are aware of this ‘under cover’ influence and just accept tacitly or whether this method of influence is unrealised.

Keywords: Family conflicts, Communication patterns; Influence techniques; Tweens (age groups); Food buying
Family conflicts and conflict resolution regarding food choices

Introduction

Families of today do not always make healthy food choices; their decision-making is influenced by children whose ideas often include unhealthy food with high sugar and fat contents like sweets for snack meals (De Bourdenaudhuij and van Ost, 1998; McNeal, 1992; Nørgaard, Brunsø, Christensen, and Mikkelsen, 2007). Parents want to serve food that constitutes a healthy diet, but they also want to ensure that their children eat food they like, among other things, in order to maintain harmony in the family (Holm, 2003; Lake et al., 2003). Children’s interest in health aspects is limited (Elverdam & Sørensen, 2003). Thus, the food choice process involves a health-pleasure trade-off and value conflicts are intensified when children are added to the family (Connors, Bisogni, Sobal, and Devine, 2001; Drichoutis et al., 2006). The public debate shows many children as eating too much unhealthy food resulting in negative consequences for public health such as obesity and lifestyle-related diseases (Christensen, 2003; Fagt et al., 2004).

Previous research has mostly focused on the outcome of the influence process, meaning whether and when children gain influence in particular areas of family food choices, yet only few studies deal with the influence process itself. Among these, focus has mainly been on interaction between husband and wife (Sheth, 1974; Spiro, 1983), interaction between parents and adolescents (Palan and Wilkes, 1997) but also on younger children’s use of influence techniques in food purchases (Marquis, 2004). Still, only limited attention has been given to family communication or interaction during food
buying; and to our knowledge, no empirical studies have focused on conflicts arising from different preference formations among family members including children, the health-pleasure trade-off, and conflict resolution techniques used by parents and tweens (aged 10 to 12) when shopping for food.

The objective of the research presented in this paper is to develop the understanding of conflicts and conflict resolution regarding food choices and health-related decision-making in families with a focus on communication, interaction and influence techniques between parents and tweens.

The remainder of the paper is organized as follows: In the first section, we discuss joint family decision-making, family communication patterns, and influence techniques used by parents and children respectively. Then we describe the empirical analysis, and we conclude with a discussion of implications and potential extensions of the research.

**Literature review**

In this section, focus is on interaction between family members in evaluation and choice of food, specifically use of various influence techniques. For this discussion, literature on family joint decision-making and children’s influence is reviewed.

Several family members’ active participation in family decision-making creates a potential for conflict, as they do not always agree or do not always make decisions in the same way (Grønhøj, 2003; Kirchler, 1988; Sheth, 1974). However, research does not specify the types of conflict nor the exact reasons for them breaking out during
family food buying, when both children and parents participate in decision-making. In this paper, we define conflicts as disagreements about food aspects among family members.

Families find resolutions to their conflicts in various ways such as direct interaction, communication or bargaining. The communication level varies among families. Moschis (1985) defines family communication as *interpersonal communication*, where socialisation agents (e.g. parents) influence a person (e.g. their tweens). Via this kind of communication parents are able to influence their children, who in turn are able to influence their parents. In order to illustrate family communication patterns, Moschis (1985) uses the *Newcomb co-orientation model*; cf. Figure I.

- Take in Figure I -

The model consists of two communication structures: *socio-orientation* and *concept-orientation*. Together the two structures create four communication patterns: *laissez faire*, *cocoon or protective*, *pluralistic* and *consensual*. Studies on family communication patterns have revealed that concept-oriented parents, including pluralistic followed by consensual parents (arrows between A and B in figure I illustrate discussions), involve their children more directly in discussions and encourage them to develop independent consumption perspectives, which means that children in these families achieve most influence (Caruana and Vassallo, 2003; Moschis, 1985; Rose et al., 2002). Nevertheless, it is still unclear whether open-minded communication is widespread in families today.
Family members use direct interaction and direct communication to try out various influence techniques to convince each other, thereby gaining influence on family decision-making. From research on family communication and interaction, we know at least four prior investigations of conflict resolution or influence techniques used in families. These studies provide valuable information on interaction between family members and their use of specific influence techniques in decision-making.

One study, Sheth (1974), is conceptual and investigates conflict resolution focusing on influence techniques. This study suggests that family members use influence techniques like problem solving, persuasion, negotiation and use of politics. Problem solving, for instance, includes information search as regards other family members’ preferences and behavioural intentions with the aim of maximizing joint utility (Grønhøj, 1998; 2002; Kirchler, 1988; Park, 1982; Sheth, 1974).

Another study, Spiro (1983), is empirical and investigates adult couple’s interaction in joint decision-making regarding the purchase of durable goods. This study identifies six different combinations of adult influence strategies resulting in various influent types or groups: Non-influents, weak influencers, cunning influencers, feeling influencers, combination influencers, and strong influencers. These influent types or groups are based on combinations of the following influence strategies: ‘negotiation’, ‘revenge’, ‘expert use’, ‘feeling utilisation’, ‘legitimation’, and ‘impression direction’. The study confirms Sheth’s (1974) conceptual suggestions about family members’ ‘negotiation’.
A third study, Palan and Wilkes (1997), has its focus on adolescents’ (12-15 years old) influence strategies and their parents’ response strategies using in-depth interviews with both parties. This study have identified four adolescent (aged 12 to 15) influence strategies: ‘negotiation’, ‘persuasion’, ‘feeling utilisation’, and ‘requests’. ‘Persuasion’ and ‘negotiation’ are the ones most frequently used, though ‘negotiation’ is the most effective one meaning that the person achieves what he or she wants. Also, adolescents realise that effective influence attempts are likely to be successful when they match their influence strategies to their parents’ decision-making styles. Furthermore, the study identifies parental response strategies: ‘negotiation’, ‘persuasion’, ‘feeling utilisation’, ‘expert use’, ‘legitimation’, and ‘direction’. ‘Negotiation’ is the one most frequently used. A comparison of adolescents and adults reveals that both use strategies such as ‘negotiation’, ‘persuasion’ and ‘feeling utilisation’. Adolescents also use ‘requests’, while parents use ‘legitimation’ and ‘direction’, which reflects the different roles that exist in a family context. The study confirms Spiro’s (1984) findings about adults using strategies like ‘negotiation’, ‘expert use’ and ‘feelings utilisation’.

A fourth study, Marquis (2004), investigates children’s use of influence strategies in family decision-making on food purchasing through a survey with ten-year old children. In her study of children aged 10 years (part of the tweens) and food, this study focuses on ‘bargaining’, ‘persuasion’ and ‘emotional strategies’ based on Palan and Wilkes (1997). Findings show a preference for persuasive strategies (e.g. ‘expressing opinions’, ‘stating preferences’ or ‘begging’) and for emotional strategies (e.g. ‘asking repetitively for a product’ or ‘being nice and affectionate’). In a comparison with Palan and Wilkes (1997) we found that both adolescents (aged 12 to 15) and young tweens (aged 10) use
‘persuasion’ as a typical influence strategy. Among the differences between the two groups is that adolescents typically use ‘negotiation’ with great success, while young tweens use emotional strategies. This is confirmed in John’s (1999) meta-analysis of previous studies, namely that children develop their use of influence strategies with age. As they grow up, they become more verbal, at the same time learning which influence strategies are the most effective. However, Marquis (2004) does not compare these young tweens’ strategies with the ones used by parents in connection with food purchasing.

A comparison of tweens’ and parents’ influence techniques for solving conflicts during food buying was not the primary objective of the reviewed studies; they do, however, make an important point of departure for the present study: younger and older children’s use of influence techniques differ, and so does that of children and their parents, but it may also differ between food and non-food products.

Individual family members face complex decision tasks due to their varying preferences, and often they are unable to detect their partner’s and children’s preference function and decision strategy (Grønhøj, 1998; 2002; Kirchler, 1988; Lerouge and Warlop, 2006; Park, 1982; Sheth, 1974). In these situations, conflict avoiding may be the easiest way to solve conflicts in decision-making (Park, 1982). Having detected different preferences in the family, family members are assumed sometimes to try to avoid conflict by pretending to agree (Kirchler, 1988). Hence, joint decision-making can in some situations be characterised as a muddling-through process. In these situations, each individual pursues his or her own decision strategy with the aim to maximize own
utility at the same time avoiding conflict. Each family member thus believes that the
decision is made jointly, although this is not the fact. This kind of joint decision-making
happens using conflict resolution techniques named conflict avoiding techniques
(Kirchler, 1993; Park, 1982).

Previous studies find that only a limited number of parent-child interactions end up in a
conflict, which could indicate that conflict avoiding also takes place during decision-
making in families with children (Atkin, 1978; Isler et al., 1987). Nevertheless, recent
studies (Foxman et al., 1989; Nørgaard et al., 2007) show that children’s influence is
increasing. This indicates that more interaction with an open-minded discussion takes
place in families with children, but that conflict avoiding happens at some level.
Maintaining family harmony is one goal for families with children and the use of
conflict avoiding techniques in food buying is an obvious example. Food choices are
sometimes bounded by a need to maintain harmony, since maintaining harmony often
will be considered as more important than a healthy diet (Lake et al., 2003). Parents
allow for family members’ different preferences and choices weighting and bringing
them together in a harmonious whole. If children do not want healthy food, healthy food
can lead to conflict rather than harmony (Holm, 2003). Therefore, it is not sufficient that
parents want to buy healthy food, if the children disagree (Holm, 2005).

Another way of using conflict avoiding influence techniques is for children to realise
that, if they take part in duties like shopping, they are liable to achieve more influence
because they help their parents. An empirical survey among Danish children aged 10 to
13 and their parents confirm that children’s active participation and help during food
buying explain children’s influence. Moreover, children achieving most influence realise the advantage of adjusting their participation and help to fit in with their parents’ set of daily routines (Nørgaard et al., 2007).

Conflict avoiding may be triggered by a desire for convenience, as family members will attempt to find the easiest and most pleasant resolution to a conflict. Nevertheless, it is still unclear whether parents use conflict avoiding techniques to dampen disagreement and discussions, letting children decide and gain purchase influence including on unhealthy food. It is also still unclear whether families use techniques such as compromises to overcome preference differences and to exploit task specialisation for food categories. For instance, children are assumed to be the ones deciding most in relation to sweet food products such as sweets, soft drinks and cereals, because their involvement or expertise in these areas surpasses that of their parents (Nørgaard et al., 2007).

Based on the literature review above, many issues regarding conflicts and conflict resolution during food choices and health-related decision-making in families need further clarification in order to understand the health-pleasure trade-off in families and how families deal with it. The purpose of this paper is to present research developing this by investigating 1) arising conflicts, 2) reasons why conflicts arise, 3) conflict resolution focusing on family communication patterns and influence techniques used by tweens and parents, and 4) the effect of the influence techniques on the final food choice during family food buying where both children and parents participate in decision-making.
Empirical design

With the purpose of developing the understanding of conflicts and conflict resolution regarding food choices and health-related decision-making in families, we combined ethnographic approaches with standard qualitative market research approaches in an exploratory empirical design involving tweens and their parents looking at both the earlier reviewed typologies as well as new aspects.

Family research uses field observations (Atkin, 1978; Kampmann, 2000; Langbourne Rust, 1993), but also ethnographic interviews and participant observation of families’ doing their shopping (Nørgaard et al., 2007). Participant observation is defined as: “An interaction between participation in other people’s daily lives combined with observation and systematically reflection about the observed” (Gulløv and Højlund, 2003). This technique originates in ethnographic fieldwork and combines observations of actual behaviour with interviews about perceptions (Flick, 2006); this is seen as appropriate in studies involving children, because children, through their own participation, are able to carry out an active role and discuss their needs (O’Kane, 2000). However, it can be difficult to get children to talk about the areas of interest such as food buying (Andersen, 2000; Andersen and Kjærulff, 2003; Fraser, 2004; Glahn, 1992; O’Kane, 2000; Mayes, 2000; Ottosen, 2002; Scott, 2000). Research with children also requires ethical considerations such as use of only respectful methods implying that the researcher should listen to and show interest in the children but also avoid patronizing them (Alderson, 2004; Banister and Booth, 2005; Christensen, 2000; Tufte, 2000). In this project, we carried out ethnographic participant observations supplemented with semi-structured interviews in actual settings.
Participant observations and semi-structured interviews

Sample. Twelve Danish families with children aged 10 to 12 participated in the participant observations and semi-structured interviews. The families were recruited through contacts at primary schools and via snowballing. The recruiting criteria specified that the participating children had to be tweens aged 10 to 12, and the participating parent had to be responsible for food buying and cooking in the family. In addition, the sample was selected to cover a range of factors that were assumed to be important for family conflicts and conflict resolution regarding food choices: parents’ education and occupation, family structure, and number of children in the household. All names used in this paper are disguised to maintain anonymity.

Data collection. The participant observation study and semi-structured interviews were carried out over a period of six months in the city of Aarhus region and in the city of Vejle region in Denmark and began in October 2005. The fieldworker spent about 3 to 4 hours with each family monitoring them during their everyday food shopping, dinner cooking and eating of weekday dinners. The interviews were mainly family interviews conducted in the supermarket as well as in the home. In addition to the more formal interviews, the fieldwork comprised observations and informal conversations with the children and their parents (Flick, 2006). In order to ensure systematic data collection, the observation guide was based on Spradley’s (1980) Descriptive Question Matrix, and the interview guide was semi-structured in a way to invite informants to answer using their own words and narrative structures.
Data analyses (using NVivo 7.0). Qualitative content analysis with hermeneutic dimensions was used to analyse the data consisting of interviews and observations. The data coding followed principles in theoretical coding being based on essential concepts from the literature review as well as from the empirical data, and was combined with thematic coding in order to compare parents and children. The software program NVivo 7.0 was used in the coding process, and further to develop a structure of associations and links, cf. Figure II (Flick, 2006; Silverman, 2005). The octagons illustrate core categories based on essential concepts from the literature review: ‘conflicts’ and ‘conflict resolution’, but also ‘communication pattern’ as an aspect of ‘conflict resolution’, and ‘influence techniques’ and ‘conflict avoiding techniques’ as aspects of ‘communication pattern’. The circles illustrate subcategories based on essential concepts from the empirical data: ‘specific reasons for conflicts’, ‘specific influence techniques’ and ‘specific conflict avoiding techniques’. The thickness of the lines illustrates how many families confirm the aspects.

- Take in Figure II –

Empirical results

Our research finds that often parents buy food on their way home from work; shopping is done in a rush, because they want to start cooking before it gets too late. Typically, one parent, usually the mother, takes care of the shopping task; sometimes taking the children shopping. However, not all children find food buying fun and prefer to do other things, which is also why it is a matter of practicality, whether children participate in food buying or not.
Conflicts

As mentioned previously, we define conflicts as disagreements about food aspects among family members. Results show that the participating family members disagree about a number of food aspects.

At home, parents disagree about meal composition such as whether they want heavy, traditional meals with meat, potatoes and gravy or more light and modern ones with more vegetables and less meat; they also disagree about how healthy the meal should be, e.g. whether to eat fast food and fish. In our study, the women prefer light and healthy meals, and the men prefer heavy and more traditional meals.

During food shopping, parents disagree with their tweens about various aspects such as which food products they have run out of (e.g. new cereal alternatives) and therefore need to buy, and which food alternatives to choose for the family dinner, e.g. salmon or fish filets, and sliced meat for sandwiches. One mother says about ketchup “…there is a fight about this one, because the kids prefer this.” … “The other one is very spicy”. They also disagree about the freshness of chosen vegetables such as cucumbers, whether their tweens should have something to nibble on when shopping for food, and how to perform purchase tasks. For instance, a boy is told by his mother to bag the bought food. Before the boy starts, his mother takes over and says that certain items must be placed at the bottom. The boy resists and says that the taco shells will be crushed if they are put in first. The mother tells the boy not to worry, as the shells are in a box. However, the taco shells end up shattered when unpacked at home.
Reasons for conflicts

As shown in figure 1, conflicts spring from especially four aspects: individual food preferences, parents’ childhood habits, home economics and health beliefs.

Individual food preferences. Family members like different food alternatives, for example within categories like sliced meat for sandwiches and ketchup. In one family, the mother likes fish while her husband doesn’t. In another family, the boy prefers pink salami, while his mother prefers the organic one. One girl is not allowed to choose green apples because her mother thinks the peel is too thick and hard. Some parents prefer food with only a low fat and sugar content in some cases, in other cases they prefer non-light products; this means that the children are not allowed to choose either food with a high content of fat and sugar or light products. For instance, a boy asks his mother if he can have a drinking-yoghurt; he is told not to choose a light alternative. This causes a conflict, because children usually prefer sweet foods and beverages – an example of a health-pleasure trade-off (Connors, Bisogni, Sobal and Devine, 2001; Drichoutis et al., 2006). Some parents want to buy organic products because of e.g. health issues; after watching a television programme about use of pesticides one mother has become an adamant organic consumer. Tweens do not perceive the problems in using conventional products to be that important.

Food preferences are inspired from various sources. Parents’ childhood including habits regarding food influences their preferences later in life. This may be a source of conflict, when the partner is used to different habits from childhood, cf. figure 1. For instance, a mother says “…I believe the reason is that I am from a family, where we were vegetarians
one way or another”, “And my husband is used to such very traditional food, gravy and potatoes…”. Conflicts may also arise when tweens find inspiration away from home, such as in *home economics*. Most tweens are taught how to cook in home economics classes, and some of them use these classes as inspiration for meals at home. This may result in conflict, if this does not fit the parents' childhood habits and the family’s everyday routines. Some of the parents hold *specific beliefs about healthiness* regarding food, for instance in two families the parents believe that light products may cause cancer. This means that the children in the family are not allowed to choose light products, which is a problem when children prefer the taste of non-light products. Other parents believe that organic milk is the best alternative for children with frequent ear problems such as inflammation of the middle ear; in these families children are only allowed to choose organic milk.

**Conflict resolutions**

When conflicts arise, families use various techniques to solve them. Below, we first discuss communication patterns, then we discuss influence techniques and third, we discuss conflict avoiding, which are all aspects of conflict resolution; cf. figure 1.

**Communication patterns**

When shopping for food parents and tweens communicate in order to solve conflicts; cf. figure 1. They discuss their choices including individual preferences (e.g. “I want tomato, cucumber… and corn”, boy) and which food items they have at home. This means that the food choices take place as a co-operation between parents and tweens. However, this only takes place in situations where the tweens make an effort to help their parents and when their attention is not attracted to something more interesting in the shop; then
tweens will leave parents with the food choices. This also reflects the fact that parents still hold the overall responsibility for shopping; they ask tweens to find various items on the shopping list and make sure they get what they need (e.g. “Check the shopping list so that we don't find that we've forgotten something when we get home!”, mother) and not only let them do the fun things such as grinding coffee, which a boy finds entertaining. Even though the communication is open, and the discussions seem to be on equal terms; parents have the last say. Moreover, health issues and different health perceptions related to food among family members are not explicitly discussed in the families; only parents’ perceptions are revealed.

**Influence techniques**

Parents and tweens use various influence techniques to get what they want. These techniques are part of the communication as a way to solve conflicts, because both parents and children are verbal in their influence attempts; cf. figure 1. One technique is to provide *ideas*. Parents get ideas that they share with their tweens (e.g. “What about this basil pesto?”, mother). Tweens either get ideas themselves or comment on parents’ ideas (e.g. a boy finds out what his mother is planning to buy and prepare for dinner, and the boy suggests something else that he would rather have). Family members also just *tell each other what they like*, e.g. one mother chooses one product of smoked saddle of pork, and the boy suggests an alternative. Another technique used by tweens is *memory*. For instance, two girls try to convince their mother that they are out of cereals. Even though they already have two kinds, they convince their mother to buy a third one. If tweens tell their parents which food they do and do not have at home, parents may perceive it as a help and find it difficult to argue, specifically if they do not
remember which food they have in stock. Another aspect of this is ‘siblings support’: sometimes children join forces in convincing their parents, making it more difficult for parents to argue. ‘Shopping lists’ are used to list required items; either the whole family sits down together to compile the list, or family members list items individually. Another technique is ‘knowledge and experience’, which is mainly used by parents. This is a matter of which food is found first because of its location in the shop; the quantity of each product chosen (e.g. number of cucumbers and yoghurts); and the choice of products not listed on the shopping list (e.g. a boy comments that his mother finds sugar and cucumbers, which she suddenly remembers that they do not have at home). Some parents with health knowledge also use this technique in order to choose healthy food.

Conflict avoiding

Several active participants and preferences in decision making make the choice of food complex. Families are busy in their everyday lives and prefer fast and easy food shopping. Therefore, they use various conflict avoiding techniques to make the decision process less complicated, thereby more convenient. So, conflict avoiding is part of the conflict resolution and the communication, but it can also be categorised as an influence technique; cf. figure 1.

One conflict avoiding technique is to ‘choose several alternatives’ instead of only one in order to comply with family members' varying preferences. For instance, one family chooses two kinds of smoked saddle of pork for sandwiches: one for the boy and one for the mother. Another family chooses two kinds of salami: one pink alternative for the
boy and one organic for the mother. This is also prevalent at the family dinner, where several dishes are served to please all family members.

Another conflict avoiding technique is ‘tacitly giving room for another family member’s specific preferences’. When tweens perceive that their parents care a lot about healthiness, they will accept choices without much arguing. In one family, the mother is so hooked on the organic way of life that the father and daughter let her live it out. Also, when tweens’s preferences are so strong that they refuse to eat, unless they get exactly what they want, parents accept it without arguing; e.g. in one family the two boys only like mackerel with sugar, which their mother lets them have “We just have to use less sugar elsewhere.” The yielding family members use the technique of ‘having their way when a particular member is not home for a specific meal’.

‘Letting the most active family member(s) decide all’ when he or she is the only one doing the shopping and cooking is another common technique. The other family members accept it, because they know that they have to participate actively to gain influence. Sometimes, parents prefer to shop for food on their own, because it is easier and quicker than bringing tweens, which requires them to listen to the tweens’ ideas. Some tweens realise that if they help their parents, they are like to achieve more influence on food choices; this technique is called ‘easing food buying’. One girl helps her mother so often that she has become a natural part in the shopping process discussing the shopping list with her mother.
Families also ‘consider other family members’ preferences’ in their food choices. For instance, a girl looks for milk in the cool counter in the supermarket and asks her mother “Don’t we need semi-skimmed milk?” Her mother answers “Yes, if Catherine [her younger sister] likes it.” The girl chooses the semi-skimmed milk after her younger sister has accepted it.

When tweens suggest food which their parents do not perceive as a good choice, the parents try to ‘circumvent the choice by suggesting something else’. For example, a girl finds a whole salmon in the cool counter and suggests that they buy it for the family dinner the same evening. Her mother says “Well...” and “They also have fish filets...?” The girl forgets about the salmon and accepts the fish filets.

**Effectiveness of tweens’ conflict resolution/ influence techniques**

The most effective influence technique used by tweens is to realize how to help parents make the shopping situation easier and quicker. These influence attempts are ‘rational’ and based on deliberations rather than non-serious ideas just coming out of the blue, as for instance when tweens are attracted by some communication material in a shop or suddenly catch sight of something they want; e.g. a girl spots a very spicy salami at a butcher’s shop and wants her mother to buy it – even though the butcher tells her that he believes it is too spicy for her. So, tweens achieve most influence when they help their parents finding what the family actually needs to buy and when they do not delay the shopping time by suggesting a lot of non-serious purchases.
Discussion

The objective of our study was to develop the understanding of conflicts and conflict resolution regarding food choices and health-related decision-making in families with a focus on communication, interaction and influence techniques between parents and tweens.

The study contributes to the understanding of the family influence process in a food buying context, which supplements previous research with the influence outcome as the main focus. This contributes to a more comprehensive understanding of family decision-making during food buying, the health-pleasure trade-off, and how the final food choice is made beyond the study of adult food choices only.

Our study provides new insight into the types of conflicts that arise during families’ food buying and the reasons for the conflicts. Different food preferences and different food-related beliefs such as health beliefs among family members generate conflicts, supporting and supplementing Connors et al. (2001) and Drichoutis et al. (2006) regarding value conflicts and health-pleasure trade-offs in families.

The research also contributes with new insight into conflict resolution during family food buying, e.g., about tweens aged 10 to 12 and how they communicate with their parents in order to achieve influence on food choices. Most families apply a very open communication style during food buying allowing room for all preferences and opinions, which could be classified as belonging to a ‘concept orientation style’ with both pluralistic and consensual communication patterns (cf. Figure I) according to the
studies by Moschis (1985), Rose et al. (2002), and Caruana and Vassalo (2003). However, parents still have the last say as a result of their being in charge of shopping and cooking.

Also we found that, in a food buying context it may not be appropriate to distinguish tweens’ influence techniques from parents’ response techniques, as in Palan and Wilkes (1997); because there is no system to who provides the first idea and consequently who is to respond. Tweens and parents alike use techniques like knowledge and experience supporting the ‘expert use technique style’ in Palan and Wilkes (1997).

Our research supports Marquis (2004) in finding that young tweens (aged 10) use persuasive techniques such as expressing opinions and stating preferences. However, in our study the tweens do not use begging and pestering, only the younger siblings (younger than 10 years). Our research also supports Marquis (2004) in finding that young tweens use emotional techniques like being nice and helpful.

Nevertheless, one of our most interesting findings is tweens’ use of the help easing food buying-technique, which supplements findings in previous research in the food and tweens area by Nørgaard et al. (2007). It also supplements findings by Palan and Wilkes (1997) about matching influence strategies to parents’ decision-making style. The tweens realizing this have developed a cleverer competence giving them more influence than other tweens. In general, the tweens in our study are verbal in their influence, which is something they develop with age according to John (1999). John (1999) also
finds that children learn which techniques are the most effective as they grow older; in our research the tweens have learnt this and use it.

As opposed to negotiation as dealt with in the study by Palan and Wilkes (1997), one technique seems more widespread in a food buying context: ‘convenience use’ and conflict avoiding. This may be a consequence of families’ busy everyday lives where they want food shopping over and done with quickly. This is somehow linked to tweens’ use of the help easing food buying technique. Family members do not spend time discussing the various suggestions or beliefs, e.g. health issues, but find ways to avoid this. Parents do not have the energy to discuss all conflicts in depth and often choose to postpone discussion for situations where there is more time. This supports studies about conflict avoiding being used in families, like e.g. Kirchler's (1993). Different preferences do not lead families to resort to compromise as in Park (1982); instead they sometimes choose both alternatives. For instance, when the tweens want mackerel with sugar, their parents put off the conflict for a later point in time and give the children what they want in order to maintain harmony, supporting Lake et al. (2003) and Holm (2005). This illustrates the health-pleasure trade-off in families, and how children use smart influence techniques in order to get what they want, which is not always healthy food. When children help parents easing food buying, parents give something in return by letting children have what they want. Nevertheless, children accept, if their parents have particular strong beliefs about, for instance, health.
To sum up, when analysing family decision making and conflicts, we may conclude that aspects of:

- Families’ busy everyday lives
- A health-pleasure trade-off
- A need for maintaining harmony
- Convenience
- Childhood habits
- An open communication pattern between parents and tweens
- Tween’s development of a clever competence in realizing that supporting parents easing food buying give more influence, and

Is having a crucial influence on conflicts, their resolution, and the outcome of influence techniques used. This is important in order to fully understand how families make decisions about food choices and to guide marketers in their food marketing directed at parents and tweens.

Future research may use the present study to further investigate family communication patterns and families’ use of influence techniques, especially about health issues. Our study could be further developed by investigating parents’ and children’s awareness of their own use of influence techniques and that of their "adversary" in order to find out how strategic children and parents, respectively, are in their influence attempts. Future research could also investigate age and gender differences reflected in children's use of influence techniques during food buying, thereby further developing Kirchler (1993), John (1999) and Marquis (2004). It seems that girls tend to be more strategic than boys,
for instance, by using the *help easing food buying* technique. Furthermore, future research could investigate other reasons for the use of different influence techniques.

Finally, our findings may be of value to marketers targeting families with children in their development of marketing communication, especially health campaigns. With the aim of supporting various family members in their attempt to convince other family members to buy certain products, marketers may find ways of supporting children as well as parents in their influence process. And especially children may gain increased influence over food choices if they get support and inspiration in ways to help and ease their parents' food buying process. Marketers could use this to design marketing communication material in a way to make children become more interested in health and to demand healthy food products. This might make children supply their parents with ideas for healthier food making health decision-making easier for parents, which could avoid the negative consequences for children of eating too much unhealthy food.
Figure I: Family communication pattern typology: The Newcomb co-orientation model

Low socio-orientation | High socio-orientation

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<td>Pluralistic</td>
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A = the child; B = the parent; X = the topic

Source: Moschis, 1985
Appendix

Figure II: A structure of associations and links based on data from the participant observations and semi-structured interviews
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CHAPTER 6: FAMILIES’ ACQUISITION OF
HEALTH-RELATED COMPETENCES IN A FOOD
BUYING PERSPECTIVE

(Article 4)

Submitted to:

Appetite
Families’ acquisition of health-related competences in a food buying perspective

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Abstract

How do families achieve health-related competences enabling them to perform preventive health behaviours such as making healthy food-choices? This paper suggests a conceptual framework outlining how families reach health-related competences. The framework will serve as a blueprint for discussing the process with relevant determinants and the specific outcome competences in the context of food buying. The paper combines psychological and sociological aspects and suggests that families’ acquisition of health-related competences is based on not only the individuals’ competences but also within-family social interaction consisting of team work, knowledge sharing and knowledge management following a concept-oriented communication structure including pluralistic and consensual communication patterns. Furthermore parental support and guidance of children are included to help children help themselves (e.g. to use and understand nutritional information) so that they will become independent of their parents in various consumer situations. The paper also suggests that health-related competences contain shared health beliefs, a mutual understanding of individual health motivations and barriers, and health agreements in the family as an umbrella for individual perspectives. Shared health-related competences may solve conflicts like health pleasure trade-offs and make families capable of carrying out preventive health behaviours such as using nutrition information and making healthy food choices, and implementing healthy eating habits in their busy everyday lives.

Keywords: Families, Tweens, Consumer socialisation, Health-related competences, Social interaction, Preventive health behaviour, Food buying
Families’ acquisition of health-related competences in a food buying perspective

Introduction

Families of today often make unhealthy food choices during food buying, and often children influence their parents to buy the unhealthy food such as sweets for snack meals (McNeal, 1992; Nørgaard, Brunsø, Christensen, and Mikkelsen, 2007). One consequence is that many children eat too much unhealthy food; and it is recognised that children’s consumption of excess unhealthy food results in negative consequences for public health such as obesity and overweight, eating disorders, and lifestyle-related diseases indicating an unnatural and unhealthy attitude towards food (Christensen, 2003; Fagt, Mathiessen, Biltoft-Jensen, Groth, Christensen, Hinsch, Hartkopp, Trolle, Lyhne and Møller, 2004; Myrland, Trondsen, Johnston and Lund, 2000; Nørgaard et al., 2007). A widely held belief is that childhood lifestyle behaviour is likely to become adult lifestyle behaviour, and that dietary habits acquired through childhood persist through adulthood; so the tendencies with unhealthy lifestyles may continue as the particular children grow up (Brown and Ogden, 2004; Cullen, Baranowski, Rittenberry and Olvera, 2000; Douglas, 1998; Lake, Rugg-Gunn, Hyland, Wood, Mathers and Adamson, 2004; Lau, Quadrel and Hartman, 1990; Ward, 1974). Taste test findings show that typically children in obese/overweight families have a higher preference for fatty foods, an under-average liking for vegetables, and an eating style that tends towards the “overeating-type” (Lvovich, 2003). So, the pattern starts in an early age and is difficult to break (Douglas, 1998).
Research finds that exposure to food promotion influences children’s consumption of less healthy food with high levels of fat and sugar content positively, primarily among obese and overweight children (Halford, Boyland, Hughes, Stacey, McKean and Dovey, 2007). As most foods marketed to children today are predominantly high in sugar and fat inconsistent with national dietary recommendations, food promotion in general is often accused of being responsible for children’s food ideas, wrong perceptions of nutrition, increased consumption of calories and development of obesity (Barwise, 1997; Linn, 2006; Story and French, 2004). These accusations are vented even though research finds that various other factors like the family and peers also influence children (Elverdam and Sørensen, 2003; Linn, 2006; Moschis and Moore, 1979; Pearson, Biddle and Gorely, 2009; Smith, 1997; Tingsley, 2003); and even though children are often attributed consumer competences like media-understanding and decision-making at a very high and mature level (Brembreck, Johansson and Kampmann, 2004; Lindström, 2003).

A number of attempts on the market in promoting healthy food to families and children do exist. Examples of successful campaigns are ‘6-a-day’ and ‘Mini Milk’; however, the documentation for habit changes as an effect of the campaigns in general is discussed; and the tendencies with unhealthy lifestyles, consumption of unhealthy food, and overweight among children and their families still exist (Berlingske Tidende, 22.05.04; Perspektiv, 03.12.03). Marketers may have been less successful in targeting the health campaigns to the right segments, both children and families, by not recognising the necessary insight to have about the segments and the executive elements to use to reach the specific segments (Smith, 1997). Some public discussed explanations
are that many of the health campaigns do not deliver a concise message that is easy to use and are not followed up by local initiatives (Berlingske Tidende, 22.05.04; Perspektiv (03.12.03). Previous research finds that families’ use of nutritional information as guidance for food choices is limited because of problems in understanding the standard labelling on, for instance, food packaging; and if children care about health aspects, they typically ask their parents and discuss the understanding with them (Nørgaard and Brunsø, 2009). The insight may have been limited about family dynamics with open communication patterns in learning processes and decision making and how this has resulted in the fact that children have never been as emancipated, articulate and market-mature, thereby consumer competent, as they are currently (Valkenburg, 2000). Health-related competences like understanding problems therefore may determine both adults’ and children’s preventive health behaviour such as use of nutritional information, healthy food choices and healthy eating habits (Grunert and Wills, 2007; Jayanti and Burns, 1998; Nørgaard and Brunsø, 2009). The acquisition of these competences thus becomes relevant for health behaviour.

Already there is an important pool of theoretical and empirical studies on how children acquire consumer competences through the perspective of the consumer socialisation process (John, 1999). However, these previous studies are mainly of a general nature and concentrate on the individual consumer, e.g. the child, and on how socialisation agents influence a person. The family as a unit in the socialisation process, and the family’s development of shared health-related competences based on social interaction in a food buying perspective remain under-researched areas. The family as a unit and the social interaction in families are relevant in a health perspective, as previous
research finds differences in purchase motives, choice criteria, product preferences, and health perceptions across but also within families, which through social interaction may be used constructively in health decisions (Elverdam and Sørensen, 2003; Nørgaard and Brunso, 2009; Pettersson, Olsson and Fjellström, 2004).

The objective of this paper is to present a conceptual framework outlining families’ acquisition of health-related competences focusing on the process including relevant determinants and the specific outcome competences in a food buying perspective. The paper combines psychological aspects focusing on the individual with sociological aspects focusing on the social settings, specifically the family context. This insight may be of relevance to researchers within human nutrition, sociology, psychology, consumer behaviour and marketing but also to marketers, parents and the society in general; as this indicates new areas to investigate in order to improve the understanding of consumer behaviour, the importance of the family context in social learning, food promotion such as health campaigns, and public health including healthy eating habits among children.

The remainder of the paper is organized as follows. First, there is a literature review containing the following specific issues 1) Food buying and choices, 2) Preventive health behaviour, 3) Consumer socialisation, 4) Family internal interaction, and 5) Family everyday traditions and practices. Based on the literature review, we develop a conceptual framework for families’ acquisition of health-related competences. Finally, we conclude with a discussion of implications and potential extensions of the framework.
Literature review

Food buying and choices

One of the most fundamental food choice models is Steenkamp’s model from 1997, which provides a general decision process focus involving various decision stages and a specific food focus by including a number of factors (physiological effects, sensory perception, personal, and environmental) influencing the decision process in a food perspective (Steenkamp, 1997). However, this model does not include social factors such as family dynamics or health-related factors. Shepherd’s food choice model from 1985 concentrates on a number of factors influencing food choice very close to the ones in Steenkamp’s model but includes in addition attitudes (e.g. towards health issues) and Social factors. However, this model does not include various decision stages or family dynamics as part of the social factors (Shepherd, 2001). The Total Food Quality Model (TFQM) developed by Grunert, Hartvig Larsen, Madsen and Baadsgaard in 1996 contributes with a view on consumers’ food quality perceptions which it divides in pre-purchase evaluations (expectations, e.g. about extrinsic cues like packaging or labelling) and after-purchase evaluations (experiences, e.g. about taste). Empirical studies have tested the model for various purposes such as measuring consumers’ perception of fish and pork quality. Results show that the quality perception depends on the consumer type indicating the importance of segmentation in order to investigate differences between groups, as for instance parents and children (Bech, Grunert, Bredahl, Juhl, and Poulsen, 2001; Grunert, Hartvig Larsen, Madsen, and Baadsgaard, 1996). However, the model neither includes social factors such as family dynamics nor health issues.
In general, these models concentrate on the individual consumer as a decision-maker and primarily on the adult consumer, thereby ignoring the relevance of social factors such as family dynamics including direct influence from other family members and the children as consumers. Furthermore, health aspects are not included thoroughly.

Families’ food buying today reflects joint decision-making with both parents and children participating actively and having influence in the decision process. Children gain high influence particularly on small and easy prepared meals, but also on unhealthy food products. This indicates the importance of viewing the family as a unit in decision-making instead of only viewing the individual consumer, the parent or the child, and on the interaction between family members, and of looking closer into families’ food choices and health behaviour (Nørgaard et al., 2007).

Adults/Parents and children are two groups of consumers which are similar on some aspects but very different on others, which makes it necessary to consider dimensions specific to both of these groups of consumers in order to understand the family behaviour. As with adults/parents a variety of factors influence children’s food preferences, choices and habits. Among these factors are product properties (e.g. physiological effects, sensory perceptions), personal factors (e.g. psychological factors, socio-economic factors), environmental factors (e.g. food promotion), and social factors (e.g. influence from relevant others such as family and peers) (Balasubramanyam, 1997; Cullen et al., 2000; Woodward et al., 1996). The differences from adult consumers are to be found within these specific factors. Active participation and influence from several persons in the decision process may create conflicts such as health-pleasure trade-offs
because of, for instance, preference and competence differences that may require specific family dynamics in order to be solved. A family perspective in food buying and choices may therefore be appropriate in many situations.

Preventive health behaviour

As already mentioned, health is not an explicit aspect in previous consumer learning models such as e.g. Moschis and Churchill’s (1978) consumer socialisation model.

Preventive health behaviour is defined as “behaviours that will prolong one’s healthy life or practices that otherwise lessen the effects of infectious disease, chronic illness, or debilitating ailments” (Jayanti and Burns, 1998: 1). For instance, a choice of healthy food is considered as preventive health behaviour, but also use of nutritional information on food labels is considered as preventive health behaviour, because it may lead to a choice of healthy food (Drichoutis, Lazaridis and Nayga, 2006). According to previous research (Jayanti and Burns, 1998) health knowledge, health abilities, health motivation and health consciousness may all be determinants of preventive health behaviour.

Before looking further into the determinants of preventive health behaviour, it may be useful to define healthy food. According to the official definitions, the proportion between the energy-giving substances in food – protein, fat and starch – in a healthy diet is 10-15 %, max. 30 %, and 55-60 % respectively as recommended by the health authorities counted in a meal, a daily diet, or a week’s mean consumption. This means that the purposeful way of looking at health is to consider the quantity and frequency of
the food consumed rather than only considering a specific food product; also
preparation has some impact on the healthiness of food (Holm, 2003a).

Health knowledge refers to a consumer’s store of health information and may determine
preventive health behaviour (Jayanti and Burns, 1998). Several research studies show
that consumers’ knowledge of public nutritional information messages is extensive.
Their perception of health and nutrition matches public information and their focus is on
key words like vegetables, variety, low fat, fibre, vitamins (Holm, 2003c).

Grunert and Wills’ theoretical framework (2007) argues that nutritional knowledge may
influence the understanding and use of nutritional information on food labels positively.
Also, research finds that education has a positive effect on nutritional information
search, and that particularly children from lower socio-economic backgrounds have a
poor diet and pay less attention to their consumption environment (Drichoutis et al.,
2006; Hanson and Chen, 2007; Moschis and Moore, 1979). Nevertheless, previous
empirical research has produced mixed conclusions concerning the relation between
health knowledge and preventive health behaviour (Jayanti and Burns, 1998; Moorman
and Matulich, 1993; Verbeke and Vackier, 2005). For instance, some research finds that
children aged 12 years possess better knowledge about differences between healthy and
less healthy food than about specific nutrient-rich foods (Douglas, 1998). Consumers
eat what they like and not what they find healthy, indicating that health knowledge does
not necessarily lead to healthy food choices (Holm, 2003c). Information campaigns
alone may therefore not be the most effective solution in the process of influencing
consumers to choose more healthy food (Douglas, 1998).
Health ability refers to consumers’ skills in performing preventive health behaviours and may determine preventive health behaviour (Jayanti and Burns, 1998; Moorman and Matulich, 1993). Previous research has shown that the complexity of standard nutritional labelling and problems deciphering technical terms, numerical calculations and percentages all influence the understanding and use of nutritional information on food labels negatively among both adult and child consumers and in family settings; consumers do not always scan food labels for nutritional information when evaluating and choosing food products (Grunert and Wills, 2007; Muller, 1985; Nørgaard and Brunso, 2009). This indicates that family members’ health-related competences such as understanding nutritional labels may impact food choices, especially the choice of healthy food.

Health motivation is a personal trait; it is a consumer’s goal-directed arousal to engage in preventive health behaviour and may determine preventive health behaviour (Jayanti and Burns, 1998; Moorman and Matulich, 1993; Verbeke and Vackier, 2005). Grunert and Wills’ theoretical framework (2007) argues that nutritional interest influences the processing of nutritional information on food labels. Empirical research has found that health motivation increases the amount of health information acquired from labels (Moorman and Matulich, 1993). Lando and Labiner-Wolfe (2007) found consumer preferences to be conflicting, i.e. their interest in having nutritional information made available to them versus not always using it. Health motivation, therefore, may not always result in subsequent health behaviour; possibly because of a health-pleasure trade-off.
In general, children’s interest in health aspects is limited (Elverdam and Sørensen, 2003), and children have more influence on the family’s purchase of unhealthy food (e.g. sweets) compared to healthy products (e.g. fruit, vegetables and fish) (Nørgaard et al. 2007), which also may indicate that children are more interested in taste than in health, following the health-pleasure trade-off. Taste tests show that children from obese/overweight families have a more pronounced preference for fatty foods, a limited liking for vegetables, and an eating style resembling that of the “overeating type” (Lvovich, 2003). Girls seem to be more interested in health than boys; and in general, women seem to pay more attention to health compared to men (Elverdam and Sørensen, 2003; Snell, Johnson, Lloyd and Hoover, 1991). When children are interested in health, it is typically rooted in their own appearance and a wish to achieve popularity among peers, while parental health interest and concerns revolve around avoiding diseases. This indicates that consumers’ health interest changes with age (Elverdam and Sørensen, 2003; Mooney, Farley and Strugnell, 2004; Ton Nu, MacLeod and Barthelemy, 1996). As children become teenagers, changes regarding food preferences and habits seem to occur, one of them being that teenagers tend to broaden their acceptance and consumption of foods that they would not touch before puberty (Ton Nu et al., 1996). Social factors become increasingly influential and teenagers sometimes choose foods which distinguish them from adults (hamburgers, soft drinks etc.). Besides, children’s desire to enter the adult world makes them sample previously disliked foods (coffee, spices, alcoholic beverages), which they begin to appreciate little by little (Ton Nu et al., 1996).
Health consciousness is an external characteristic of a person concerning the degree of readiness to carry out health actions. Also it is an integrated part of consumers’ lifestyles and daily activities and may determine preventive health behaviour (Jayanti and Burns, 1998; Kraft and Goodell, 1993; Schifferstein and Ophuis, 1998; Snell et al., 1991). Research finds that, in general, women are more health conscious than men (Verbeke and Vackier, 2005). However, the research in this area focusing on children is limited.

Health campaigns may also determine preventive health behaviour. Food communication targeted at children is often blamed for being responsible for children’s food ideas, wrong perceptions of nutrition, excess consumption of calories and development of obesity, since most of this food is predominantly high in sugar and fat inconsistent with national dietary recommendations (Goldberg, Gorn and Gibson, 1978; Linn, 2004; Story and French, 2004; Tufte, 1999). However, the communication in focus primarily consists of television commercials, whereas new interactive media like the Internet and mobile phones have entered the scene and may prove even more important among tweens. Also, in-store promotion and packaging design seems relevant to concentrate more on, as many family decisions about food choice are made in the food stores (Nørgaard et al., 2007; Nørgaard and Brunsø, 2009), and as only few studies concentrate on child-targeted promotions of healthy food in supermarkets and other food stores (Berry and McCullen, 2007). Research finds that, for instance, less healthy foods such as breakfast cereals with high levels of sugar, refined grains and trans-fat are most likely to use visual communication forms by featuring child-oriented
communication such as spokes-characters, themed cereal shapes or colours, and child incentives on cereal packagings (Berry and McCullen, 2007).

Many European countries have a tradition for trying to improve its population’s health and to prevent diseases through various political initiatives as well as voluntary agreements among food companies and NGOs (Holm, 2003c). One classic measure is information to make people quit bad habits in exchange for healthier ones. Examples of previous health campaigns are ‘Whole grain campaign’ (whole grain bread), ‘Scrape the bread’ (butter), ‘5-a-day’ (fruit and vegetables) and ‘Minna and Gunnar’ (fish) (Holm, 2003b; Scholderer and Grunert, 2001). The information campaigns are subject to certain criticism since typically they solely focus on the individual’s responsibility for their health (Holm, 2003c). Other criticism points that using a top-down approach by promoting health generally to a large number of consumers in order to influence their health awareness is less effective; whereas a bottom-up approach following social marketing principles that focus on behavioural changes is more successful (Young, Anderson, Beckstrom, Bellows and Johnson, 2004). Research finds that information or knowledge do not necessarily lead to a change of habit; other initiatives are needed, such as infotainment and new interactive media, to make consumers apply their knowledge about nutrition to practice, make it easy to become healthy and reach not only adult consumers (Jensen, 2003; Scholderer and Grunert, 2001; Verbeke and Vackier, 2005).

Consumer socialisation and competences

A consumer socialisation perspective has commonly been applied in research on children’s development as consumers and development of consumer competences. In
this paper, acquisition of health-related competences is considered as a learning process being part of consumer socialisation. Thus, this section discusses the concepts of socialisation and consumer socialisation based on previous theories and empirical research in these areas.

Socialisation is defined as “the process by which individuals acquire the knowledge, skills, and dispositions that enable them to participate as more or less effective members of groups and the society” (Brim, 1966; Ward, 1974: 2). Frequently socialisation is referred to as processes by which individuals learn to participate effectively in the social environment as well as learning the social roles and the behaviour associated with those roles (Ward, 1974). This interpretation is interesting in the perspective of families, since family members need to act in a team and undertake various roles in family decision processes; cf. the previous section on family decision-making during food buying. So, in order to learn to act in a healthy way, family members need to become socialised, since health behaviour is considered as a team work more than an individual behaviour.

Consumer socialisation is one part of the socialisation; it is defined as “processes by which young people acquire skills, knowledge and attitudes relevant to their function as consumers in the market” (Ward, 1974: 2). As Grønhøj (2003) states, the definition of consumer socialisation includes a process, a result and a utility element. The process element refers to a learning process in which young people become consumers. The result element refers to consumer competences consisting of “… skills, knowledge and attitudes…” The utility element refers to the results being useable and more precisely “… relevant to their function as consumers in the market.” (Grønhøj, 2003; Moschis
and Moore, 1979). These consumer-relevant competences may include considering health in food choices, i.e. health-related competences, making consumers capable of performing preventive health behaviours. Previous research finds that the outcome competences of socialisation determine behaviour (Ward, 1974) and that health ability, among other factors, determine preventive health behaviour (Jayanti and Burns, 1998: 1). Since health abilities are considered a subset of health-related competences, this may indicate that health-related competences determine preventive health behaviour, rendering these competences relevant.

In this paper, consumer socialisation will be used as a point of departure in the analysis of families’ acquisition of health-related competences, which are here defined as processes by which family members acquire shared health-related skills, knowledge and attitudes relevant to their functioning as consumers in the market place and furthermore to their preventive health behaviour. In the following, we discuss the consumer socialisation process and results based on previous literature.

**Consumer socialisation process**

Previous research suggests two perspectives on the process of human learning including consumer socialisation:

- Cognitive development theory (a cognitive perspective), and
- Social learning theory (a behavioural perspective)

(Moschis and Churchill, 1978; Moschis and Moore, 1979; Valkenburg and Cantor, 2001). We thus employ a psychological perspective focusing on personal aspects such
as individual cognitions, and a sociological perspective focusing on environmental aspects and social settings such as the family context (Hedegaard and Fleer, 2008).

*Cognitive development theory* considers the individual consumer isolated and how consumers learn based on a cognitive-psychological process. This perspective views the formation of cognitive structures, i.e. an organization of knowledge and experience in memory, at specific age stages and suggests that consumer competences are age-dependent (Berk, 2003; Hansen, Halling and Nielsen, 2002; John, 1999; Roedder, 1981; Valkenburg and Cantor, 2001). This theory has its origin in the French psychologist Piaget’s stage theory which has been further developed by, for instance, John (1999) in a meta-analysis of studies on children’s consumer socialisation viewed from a cognitive perspective. However, children’s development cannot be measured solely on chronological age (Hedegaard and Fleer, 2008).

*Social learning theory* considers the consumer in a social context and how the consumer learns based on a social process consisting of interaction with the environment consisting of socialisation agents like for instance family, peers, and teachers at school (Moschis and Churchill, 1978; Moschis and Moore, 1979). In general, social learning views the consumer as learning through either her/his own or the agents’ experience. This involves a sociological perspective that focuses on the family context as a social setting (Hedegaard and Fleer, 2008).

The two perspectives supplement rather than complement each other and should be integrated according to Moschis and Churchill (1978), Moschis and Moore (1979), Valkenburg and Cantor (2001), and Hedegaard and Fleer (2008). Moschis and Churchill
(1978) have developed a conceptual model of consumer socialisation integrating cognitive development theory and social learning theory, cf. Figure I.

Figure I: A conceptual model of consumer socialisation

The model contains three main elements: Antecedents, Socialisation processes, and Outcomes. The social structural variables include factors such as socioeconomic status, gender and birth order. Age or life cycle position refers to a person’s lifetime during which the learning takes place; cf. the cognitive development theory. These antecedent variables may influence the socialisation outcome both indirectly and directly (Moschis and Churchill, 1978). The agent-learner relationships refer to the social mechanisms through which the agent influences the learner; cf. the social learning theory. These socialisation process variables may influence the socialisation outcome directly (Moschis and Churchill, 1978). Learning properties refer to a variety of individual consumer competences (Moschis and Churchill, 1978) such as skills, knowledge and attitudes (Ward, 1974); cf. the definition of consumer socialisation.
Empirical studies have investigated several aspects of children’s consumer socialisation influenced by various factors. For instance, research finds that family and peers as socialisation agents are the most influential factors in children’s lives and influence food choices; as children grow up, peers become the strongest influence source (Balasubramanyam, 1997; Brown and Ogden, 2004; Douglas, 1998; Smith, 1997). For instance, research finds that peers influence children’s consumption of healthy food negatively while influencing the consumption of less healthy food positively (Cullen et al., 2000; Woodward et al., 1996).

Moschis and Churchill’s model is very general and concentrates on the socialisation of only children. With the purpose of analysing families’ acquisition of health-related competences in a food perspective, we have chosen Moschis and Churchill’s (1978) model as a starting point the aim being to further develop and modify it focusing on food buying, health, families’ shared competences, dual influences in the family, and everyday traditions and practices. This will be discussed further in the following.

**Consumer competences**

Families’ shared health-related competences are here defined as *shared health knowledge, health skills and health attitudes* relevant to the families’ functioning as consumers in the market place and to their performance of preventive health behaviour such as healthy food choices (Ward, 1974; Moschis and Churchill, 1978; Nørgaard and Brunsø, 2009).

Previous research has already investigated consumer competences focusing on various issues (John, 1999). However, the research is spare on several areas, and for instance it
primarily focuses on *individual* consumers’ competences such as the child’s competences. For instance, studies find children’s consumer competences such as information processing and understanding advertising intent vary with the age stage (Davidson, 1991a; 1991b; Gregan-Paxton and John, 1997; Oates, Blades and Gunter, 2001). Research on *shared* competences in families is still an unclear but relevant research area in order to avoid health-pleasure trade-offs (Connors, Bisogni, Sobal and Devine, 2001; Drichoutis *et al.*, 2006).

In a meta-analysis of previous studies on children’s consumer socialisation in a cognitive perspective, John (1999) discusses consumer socialisation results or competences focusing on the following issues: Knowledge about transactions, Purchase influence, Decision-making skills, and Knowledge about ads and persuasion. However, the research included in this meta-analysis concentrates on children’s consumer competences in a broad and general perspective and does not include food aspects, health aspects or shared competences in families.

Many children may be knowledgeable about food transactions as they often participate and help during family food buying (Nørgaard *et al.*, 2007). Children’s competence in food purchase influence is growing. Their modus operandi is various smart and effective influence techniques that help them achieve the desired food, such as unhealthy sweets (Nørgaard *et al.*, 2007). Children’s competence ‘decision-making skills’ includes, for instance, information search and use of various decision-making strategies (Davidson, 1991a, 1991b; Klayman, 1983). Their competence knowledge about ads and persuasion concentrates on television commercials, e.g. Distinguishing commercials from programs, Understanding ad intent, Recognising bias and deception
in ads, Using cognitive defences against ads, Knowledge of ad tactics and appeals (Goldberg et al., 1978; John, 1999; Jørgensen, Bjørnebekk, Jarlbro and Tufte, 1992; Nielsen, 2002; Oates, Blades and Gunter, 2001; Robertson and Rossiter, 1974; Tufte, 1999; Valkenburg, 2000; Ward, Wackman and Wartella, 1977). However, not much of the child-research mentioned above deals with health-related competences (i.e. health knowledge, health skills, or health attitudes) nor competences in a food buying perspective.

According to the cognitive development theory, adult or parental competences may in many aspects be very similar to those of children, though on a higher level because of their age. In general, much more research in this area has been carried out among adults compared to among children. For instance, research has been carried out on adult consumers’ health knowledge and ability such as the understanding and use of nutrition information on food labels (Drichoutis et al., 2006; Grunert and Wills, 2007; Jayanti and Burns, 1998; Moorman and Matulich, 1993; Muller, 1985; Weaver, 2003). Based on empirical research, public debate indicates a need for a new nutritional label due to adult consumers’ failing to understand the existing ones (TV2 Nyhederne, 26.03.08). However, this research mainly focuses on adult consumer competences, whereas not much research investigates parental consumer competences, which may vary from adult competences in a family perspective where parents are responsible for their children. Nørgaard and Brunsø (2009) is an example of a study investigating children’s and their parents’ health-related competences in understanding and use of nutritional labels in food choices. Nevertheless, shared health-related competences in families is still a less researched area.
Family internal interaction

If more than one family member participates actively in decision-making during food buying, as described in the section regarding food buying, it may give rise to conflict due to a clash of preferences. These conflicts may be resolved through social interaction where family members use various influence techniques. Conflicts may also be avoided in order to maintain harmony and a cosy time in the family (Grønhøj, 2003; Kirchler, 1988; Marquis, 2004; Palan and Wilkes, 1997; Sheth, 1974).

Consumer learning or socialisation in families is now considered a broader concept than before (e.g. in Moschis and Churchill’s, 1978, model), since influence can go in both directions: from parents to children but also from children to parents (Ekström, 1995; Foxman, Tansuhaj and Ekström, 1989; Grønhøj, 2002).

Traditional socialisation studies primarily concentrates on parents’ influence on children, and the influence measured mostly consists of modelling and reinforcement (Moschis and Moore, 1979). Parents have a gradually increasing influence on their children’s health beliefs and behaviour (Lau, Quadral and Hartman, 1990). Modelling in families includes situations with parents showing a good example demonstrating healthy behaviour (Pearson et al., 2009), which may be more effective in improving a child’s diet than attempts at dietary control (Brown and Ogden, 2004); parents telling or instructing their children about basic behaviour and preventive health behaviour (Moschis and Churchill, 1978; Neeley, 2005). Modelling may also include situations with children telling their parents about more modern aspects such as how to become popular among peers nowadays (Elverdam and Sørensen, 2003; Linn, 2006; Moschis
and Moore, 1979). Reinforcement in families includes situations where parents acknowledge children’s influence attempts and children will therefore learn that their influence techniques work; and situations with children accepting and eating food served by their parents (Nørgaard et al., 2007). Previous literature on parental control and children’s diets is confusing according to Ogden, Reynolds and Smith (2006). Parental control is not necessarily a reaction to children’s overweight but may exist before (Duke, Bryson, Hammer and Agras, 2004; Liem, Mars and Graaf, 2004). The mother’s educational level is one factor that influences parenting practices: the higher education, the more frequent consumption of fruit and vegetables, restrictions, verbal praise, negotiations, and restrain from negative modelling (Vereecken, Keukeler and Maes, 2004).

Later, focus on social interaction in families becomes more central, and the concept is defined to include direct interpersonal communication (Moschis, 1985; see Figure 2), which, among other things, means family members’ direct influence on each other. This is related to previous research findings saying that the family communication pattern has changed and has become more open and democratic allowing more discussions in many families, cf. concept orientation (Caruana and Vassallo, 2003; Chan and McNeal, 2003; Le Bigot, 2000; Moschis, 1985; Rose, Boush, and Shoham, 2002). Research finds that children with indulgent parents consume more fruit than children with authoritarian parents (Kremers, Brug, Vries and Engels, 2003).
Children today are allowed a greater ‘say’, and parents pay more heed to their children (Tufte, 1999). Many families today have busy everyday lives involving numerous activities which creates a need for new ways of handling their everyday lives. One way is to involve children more in practical matters and allow them more influence. Children’s influence is increasing in many situations (Belch, Belch and Ceresino, 1985; Foxman et al., 1989; Hansen et al., 2002; Jenkins, 1979; Lee and Beatty, 2002; McNeal, 1992), for instance during food buying (De Bourdenaudhuij and Van Oost, 1998; Marquis, 2004; Nørgaard et al., 2007). Families often view food buying as a team work, and in many situations children actually do help make the family’s everyday life easier. Some might argue that children with influence should be considered as spoilt children, but often children’s influence could also be considered necessary to cope with the family’s everyday life. Therefore, open family communication patterns are part of the

![Figure 2: Family communication pattern typology interpreted by relations from Newcomb’s ABX paradigm](image)

A = the child; B = the parent; X = the topic
Source: Mosehls, 1985
social interaction in families and imply dual influences with children influencing their parents as well as parents influencing their children (Moschis, 1985).

Ekström (1995, p. 24) defines the concept of influence in family decision-making as “a change in a person’s dispositions, as a result of interaction between parents and children.” Grønhøj (2002) defines influence as a competence enabling the achievement of specific results. Influence as referred to above is thereby characterised as direct, implying that parents and children interact by using various influence techniques to achieve what they want (Sheth, 1974; Spiro, 1983; Palan and Wilkes, 1997; Marquis, 2004). Influence can also be more indirect, implying that parents and children act based on beliefs about each other’s preferences without direct interaction between parents and children, cf. subjective social norm in, for instance, the Theory of Reasoned Action and the Theory of Planned Behavior (Ajzen, 1991; Fishbein and Ajzen, 1975). Both influence types are widespread today. However, the direct influence as part of open family communication patterns is here considered as most important in relation to their acquisition of health-related competences, since family members are expected to learn much from talking together about and discussing their individual learning properties and perspectives.

Parents’ influence on children is called socialisation, whereas children’s influence on parents is called reciprocal socialisation, which indicates that parents may also learn from their children (Moore, Wilkie and Lutz, 2002). Children are under heavy exposure to marketing communication and they discuss many issues with their peers; therefore they may learn something useful to share with their parents (Linn, 2006; Tufte, 1999).
Influence from both parents and children, i.e. *dual influence*, in family decision-making during food buying implies that situations of disagreements and conflict may arise and need resolution as a result of potential preference gaps between parents and children (Grønhøj, 2003; Kirchler, 1988; Sheth, 1974), for instance, when children exert their influence with ideas of unhealthy food stemming from food market communication (Goldberg *et al.* 1978; Linn, 2004; Story and French, 2004).

Previous research finds that parents have an impact in their children’s health behaviour (Tingsley, 2003), and that the family environment such as parents’ eating behaviour influences children’s breakfast behaviour (Pearson *et al.*., 2009). Other research finds that parents typically think that their children preferably should develop healthy eating habits but that they should develop their own diet habits independent of their parents interfering, as it is important that children like the food they eat (Holm, 2003d). However, only a limited number of empirical studies have investigated whether children’s influence on the family buying decision process can result in consumer socialisation of the parents (Ekström, 1995), and not much research has investigated whether children influence parents’ health-related competences. This indicates a need for investigating socialisation agents’ influence within the family in a broader perspective. It is not sufficient to look at only parents’ influence on children or to look at only parents’ or children’s health knowledge, skills and attitudes, since both parents and children may influence each other successfully.
Everyday traditions and practices

Families’ everyday traditions and practices are considered as part of the environmental or institutional influence in learning processes and decision making; they constitute a sociological but also a cultural-historical perspective indicating the importance of the family context, and these traditions and practices may influence internal interaction and decision processes in the family but also families’ health practices (Christensen, 2004; Hedegaard and Fleer, 2008; Nørgaard et al., 2007). For instance, families in all cultures use eating as a context in which to establish patterns of behaviour and interaction, and processes around food are used to socialize the child (Neelay, 2005; Stratton, 1997).

Traditions include being together as a family at the evening meal, as this meal is often the only meal where many families actually spend time together in their busy everyday lives. This increases the importance of maintaining family harmony and avoiding the risk of ending up with a frustrating dinner, which may influence how the food buying and meal preparation practices are performed and by whom. For instance, this could be a reason why children do not gain influence on this meal (Holm, 1997; 2003; Lake et al., 2003; Nørgaard et al., 2007). Many families want to eat healthy food and do consider ways to change their eating habits, but often nothing comes out of it as it is too complicated for them to fit it into their daily routines, among other things because it requires considerations of all family members (Holm, 1997; 2003c; 2003e).

Christensen’s (2004) model of the health-promoting family outlines that health practices are influenced by family practices as part of family eco-cultural pathways. The family eco-cultural pathway is the way in which families engage in and utilise the resources at
their disposal. This means that families have their own goals and values that they pursue through their daily routines or everyday practices.

Hedegaard and Fleer’s (2008) model of children’s learning and development outlines that children’s learning is influenced by their participation in institutional practice. More precisely this model considers the importance of the family context in children’s development focusing on their active participation in family everyday traditions and practices.

Nørgaard et al.’s (2007) model of family decision-making during food buying outlines families’ food decision processes as being influenced by their everyday routines, or more precisely that family food activities unfold around daily routines, and that children gain most influence on family food when they adjust their participation to fit in with their parents’ set of daily routines.

Other research finds that involving children in supermarkets also comprises bringing-up children and consumer education as an extension of the home; which though may make some parents feel that involving children is stressful and exhausting and make these parents want to avoid the involvement (Pettersson, Olsson and Fjellström, 2004).

This indicates that involving children in daily family practices, including discussions of food-related issues such as health, may improve children’s but also the family’s competences in various areas such as health understanding, food buying and meal preparation, which again may make it easier to change eating habits, as all family members are already involved in the considerations.
Conceptual framework of families’ acquisition of health-related competences in a food buying perspective

Based on the literature review above, we provide a framework of investigations of families’ acquisition of health-related competences in a food buying perspective by emphasising elements of *food buying, health, dual influences, everyday traditions and practices, and shared competences*, thus (see Figure 3).

**Figure 3: Conceptual framework of families’ acquisition of shared health-related competences determining families’ food decision-process**

Learning processes

- **Antecedents**
  - Individual life stage
  - Socio-structural variables

- **Individual learning outcomes**
  - Health motivation
  - Health consciousness
  - Individual health-related competences

- **Everyday learning outcomes**
  - Everyday traditions and practices
  - Families’ internal interaction and dual influences

- **Shared learning outcomes**
  - Families’ shared health-related competences

- **Families’ food decision-process**
  - School
  - Peers
  - Food promotion
  - Health campaigns
  - Food labels
  - Point-Of-Sale
Figure 3 outlines the conceptual framework suggested in this paper. The main elements of the framework are classified, though not illustrated, into antecedents, learning processes and learning outcomes, as discussed in Moschis and Churchill (1978). Furthermore, our framework draws on and emphasises several other theoretical aspects such as food choice and food buying processes, health, dual influences, everyday traditions and practices, and shared competences in order to make a comprehensive framework of families’ acquisition of health-related competences as a determinant of family decision making in food buying:

1) In order to include food choices and food buying, a focus on determinants of food choices such as food promotion, health campaigns and food labels but also school and peers is integrated based on fundamental food choice models by Steenkamp, Shepherd and Grunert et al., and a focus on families’ decision process during food buying is integrated based on Nørgaard et al.’s model.

2) In order to include health, a focus on preventive health behaviour and its determinants (i.e. health knowledge, health ability, health motivation, health consciousness and health campaigns) is integrated based on Jayanti and Burns (1998); also a focus on food labels is integrated based on Grunert and Wills (2007) and Nørgaard and Brunso (2009).

3) In order to include family internal interaction and dual influence, the environmental perspective focusing on social interaction consisting of both parents and children’s influence attempts is integrated based on Hedegaard and

4) In order to include *family everyday traditions and practices*, this is added based on Christensen’s (2004) model of the health-promoting family, Hedegaard and Fleer’s (2008) model with a sociological and culture historical institution perspective, and Nørgaard et al.’s model of family food decision processes (2007).

5) In order to include *families’ shared competences*, the concept of children’s consumer competences from Nørgaard et al.’s model (2007) is extended to families’ shared health-related competences in order to bring in more focus on the family as a unit rather than the individual family member and the importance of understanding each other’s perspectives based on Edwards (2005).

**Antecedents**

**Individual life stage**

The age and life cycle position variables may influence families’ acquisition of shared health-related competences indirectly via family internal interaction processes. Life cycle position includes various stages of life, cf. the cognitive development theory. Here, there will be a distinction between parents and children, but also among children in different age groups or stages like babies (0-2 years), children (2-7), tweens (7-11 years), teenagers (11-16), since these groups may vary on several aspects such as health (Edwards, 2005; Elverdam and Sørensen, 2003; John, 1999; Moschis and Churchill, 1978; Moschis and Moore, 1979; Valkenburg and Cantor, 2001).
Socio-structural variables

The socio-structural variables including gender, socio-economic background, birth order, education and occupation may influence the acquisition of shared health-related competences indirectly via family internal interaction processes (Drichoutis et al., 2006; Elverdam and Sorensen, 2003; Hanson and Chen, 2007; Holm, 1997; Lvovich, 2003; Moschis and Churchill, 1978; Moschis and Moore, 1979; Snell et al., 1991; Verbeke and Vackier, 2005).

Learning processes

Health motivation and health consciousness

Health motivation and consciousness may determine preventive health behaviour, thereby also family decision processes (e.g. collection and use of nutritional information, and choice of healthy food products) via family internal interaction (Jayanti and Burns, 1998).

Everyday traditions and practices

Family everyday traditions and practices are considered as part of the environmental influence within the family context and may influence the acquisition of shared health-related competences via family internal interaction processes (Christensen, 2004; Hedegaard and Fleer, 2008; Nørgaard et al., 2007).

School, Peers, Food promotion, Health campaigns, Food labels, Point-Of-Sale

Dominating external influence agents may be the school, peers, food labels (e.g. nutrition information) and in-store promotion (e.g. endorsers demonstrating preparation and consumption of healthy food, taste samples, entertainment, events involving
interactivity, and various point-of-sale material) (Campbell, 1969; Drichoutis et al., 2006; Elverdam and Sørensen, 2003; Grunert and Wills, 2007; Hedegaard and Fleer, 2008; Jayanti and Burns, 1998; Moorman and Matulich, 1993; Moschis and Churchill, 1978; Moschis and Moore, 1979; Muller, 1985; Smith, 1997). Through modelling, reinforcement and social interaction these external agents may influence families’ shared health-related competences (Moschis and Churchill, 1978; Moschis and Moore, 1979). The external agent-learner relationships may vary between parents and children individually. For instance, children frequently watch television, use the Internet and mobile phones, and as they grow older they learn from their peers. Popularity among peers is important, and children will go far to become popular or even frontrunners on certain aspects (Elverdam and Sørensen, 2003; Linn, 2004; Moschis and Moore, 1979; Smith, 1997; Tufte, 1999).

Families’ internal interaction and dual influences

Dominating internal influence agents may be the closest family members, i.e. parents, children and siblings (Caruana and Vassallo, 2003; Ekström, 1995; Moschis and Churchill, 1978; Marquis, 2004; Moschis, 1985; Moschis and Moore, 1979; Nørgaard et al., 2007; Palan and Wilkes, 1997; Pearson et al., 2009; Rose et al., 2002; Tingsley, 2003). By means of modelling, reinforcement and social interaction these internal agents may influence the family’s shared health-related competences. Social interaction is considered as the most important learning type here and will therefore be discussed further below.

Within-family social interaction is here considered as dual influence including listening, knowledge sharing, open communication, team work, direct influence attempts and
response as well as parent-child discussions of individual perspectives on a more equal level, as a part of the concept-oriented communication patterns in families (Belch et al., 1985; Caruana and Vassallo, 2003; Chan and McNeal, 2003; Ekström, 1995; Foxman, Tansuhaj and Ekström, 1989; Grønhøj, 2002, 2003; Hansen et al., 2002; Jenkins, 1979; Kirchler, 1988; Le Bigot, 2000; Lee and Beatty, 2002; Marquis, 2004; McNeal, 1992; Moore et al., 2002; Moschis, 1985; Nørgaard et al., 2007; Nørgaard and Brunsø, 2009; Palan and Wilkes, 1997; Rose et al., 2002; Sheth, 1974; Spiro, 1983).

Interaction also includes knowledge management: the family must exploit family members’ knowledge when, for instance, making health agreements, e.g. healthy weekdays including a Fish day and a Fruit day and unhealthy weekends including Friday treats. Even though children may be considered highly competent in various areas of consumer life (Brembeck, Johansen, and Kampmann, 2004), they still need their parents’ control, support and supplement and to discuss issues with their parents to put their health views into perspective (Nørgaard and Brunsø, 2009). Therefore, this interaction also includes parents’ guidance to help the children help themselves and become independent of their parents (Edwards, 2005).

The individual competences of parents and children may differ due to age differences; cf. the cognitive development theory; for instance, internal family collaboration as described above requires children as well as parents to be able to view things from another’s viewpoint, which for children will be the case from about the age of 7 (Edwards, 2005; John, 1999). Parents’ as well as children’s individual health-related competences are considered as a valuable and necessary input in family internal interaction processes (Nørgaard and Brunsø, 2009). The more the family uses each
individual’s unique competences, the better the result. Input from several persons expands perspectives on health issues which may improve the competences of the family as a unit, thereby preparing them for preventive health behaviours, including healthy food choices.

**Learning outcomes**

**Individual health-related competences**

Individual health-related competences are defined as *individual* health knowledge, health skills and health attitudes (Jayanti and Burns, 1998; John, 1999; Ward, 1974; Moschis and Churchill, 1978). These competences may determine the family’s shared health-related competences by providing decisive input to the internal interaction in the family (Nørgaard and Brunsø, 2009).

**Families’ shared health-related competences**

Families’ shared health-related competences are defined as *shared* health knowledge, health skills and health attitudes (Ward, 1974; Moschis and Churchill, 1978).

‘*Shared*’ means that family members are aware of and understand each other’s health perspectives, including health knowledge, health skills, and health attitudes for the purpose of solving conflicts (Edwards, 2005). A family’s shared *health knowledge* includes a shared knowledge of health issues such as nutrition (Grunert and Wills, 2007; Jayanti and Burns, 1998; Moorman and Matulich, 1993; Nørgaard and Brunsø, 2009). A family’s shared *health skills* include a shared understanding of nutritional information on food labels, including cues and technical schemes, and how to use this information in food choices (Drichoutis, *et al.*, 2006; Grunert and Wills, 2007; Jayanti and Burns, 1998; Moorman and Matulich, 1993; Muller, 1985; Nørgaard and Brunsø, 2009;
A family’s shared health attitudes include shared health beliefs, mutual understanding of health motivations and barriers (e.g. health, looks, population among peers) and shared health agreements about health behaviour, e.g. sweets only on weekends, a shared natural and healthy attitude towards food, and a shared focus on and prioritising of health in food choices (Elverdam and Sørensen, 2003; Nørgaard and Brunso, 2009).

Shared competences are important, because if, for instance, parents do not understand their children’s motives, it may result in incorrect understandings of each other’s food preferences and a permanent conflict in the family (Hedegaard and Fleer, 2008; Nørgaard and Brunso, 2009). Shared competences may hinder a health-pleasure trade-off and maintain harmony in the family, and at the same time enabling families to integrate and maintain healthy food choices and healthy eating habits. This may also work as an umbrella for stronger individual competences, perspectives, preferences and behaviour and may furthermore make children more interested in health and come up with ideas for healthy food when shopping for food (Connors et al., 2001; Drichoutis et al., 2006; Elverdam and Sørensen, 2003; Holm, 2005; Lake et al., 2003; Nørgaard et al., 2007; Nørgaard and Brunso, 2009).

**Families’ food decision process**

Families’ shared health-related competences may determine their decision processes during food buying. For instance, shared health-related competences may keep conflicts at bay, such as health-pleasure trade-offs, determine whether family members check nutrition information, determine the degree of healthiness of food choices, as well as
role distributions, such as whether children or parents act as ‘health influencers’, ‘collect nutritional information’ and/or ‘choose health food products’ (Edwards, 2005; Nørgaard et al., 2007; Nørgaard and Brunsø, 2009).

**Discussion**

**Conclusions**

The objective of our conceptual framework was to outline families’ acquisition of health-related competences focusing on the learning process with relevant determinants and the outcome competences in a food buying perspective combining psychological and sociological aspects.

The conceptual framework may contribute to the understanding of how families achieve health-related competences and the specific content of these competences in a food buying perspective using a consumer socialisation point of departure. The health-related competences are important for families to perform preventive health behaviour such as use of nutritional information on food labels, healthy food choices and healthy eating habits (Grunert and Wills, 2007; Jayanti and Burns, 1998; Nørgaard and Brunsø, 2009). These competences, therefore may also determine families’ decision-processes during food buying (Edwards, 2005; Nørgaard et al., 2007; Nørgaard and Brunsø, 2009). A family’s shared competences are important as an addition to the individual family members’ competences, because through a deeper insight into individual perspectives, they may hinder a health-pleasure trade-off (Connors et al., 2001; Drichoutis et al., 2006) and may work as an umbrella for stronger individual health perspectives, preferences and behaviour (Elverdam and Sørensen, 2003).
Our framework supports the integration of cognitive and social dimensions in the consumer socialisation and learning process as put forward by Moschis and Churchill (1978). However, our framework provides new insight in consumer socialisation and learning by integrating various other aspects such as a food buying perspective, health aspects, dual influence social interaction (influence from both parents and children), family everyday traditions and practices, and the family’s shared health-related competences.

Our framework adds *family decision processes during food buying*, as the shared health-related competences may determine how healthy families’ food choices and other preventive health behaviours in fact are, extending previous research finding that health abilities influence preventive health behaviour (Grunert and Wills, 2007; Jayanti and Burns, 1998; Nørgaard and Brunso, 2009).

Our framework focuses on *health* by including health motivation and health consciousness as determinants in the learning process as well as health-related competences (health knowledge, health ability, and health attitude) resulting from the process, extending previous research by putting the concepts of health motivation, consciousness and ability into a new perspective (Jayanti and Burns, 1998).

Our framework focuses on *the family as the consumer unit* and the *social interaction between parents and children* in the learning process. Social interaction in the family is considered as a dual influence process, thereby family dynamics; it includes listening, knowledge sharing, communication, direct influence attempts and response, team work, discussions of individual learning properties and knowledge management (Nørgaard et
Here parents and children are equal as a part of the concept-oriented communication patterns in families (Moschis, 1985; Caruana and Vassallo, 2003). This extends the use of the concept of family communication by putting it into a health perspective in consumer learning.

Our framework adds *everyday traditions and practices in the family* supporting the importance of the family context as a social setting in the learning process (Christensen, 2004; Hedegaard and Fleer, 2008).

Our framework adds the family’s *shared health-related competences* focusing on shared health beliefs, mutual understanding of health motivation and barriers, and shared health agreements. This enables families to integrate and maintain healthy food choices and healthy eating habits and at the same time solving conflicts like the health-pleasure trade-off and maintaining harmony, but in addition also work as an umbrella for stronger individual health perspectives, preferences and behaviour (Connors *et al.*, 2001; Drichoutis *et al.*, 2006; Edwards, 2005; Elverdam and Sørensen, 2003; Holm, 2005; Lake *et al.*, 2004). This may also make children more interested in health and make them come up with ideas for healthier food during family food buying (Nørgaard *et al.*, 2007). This extends the previous view on only individual learning properties or consumer competences.

To sum up, several factors are relevant in the process of how families achieve health-related competences. Health motivation and consciousness, and the family context including everyday traditions and practices, and social interaction consisting of dual influence including, for instance, team work, knowledge sharing and knowledge
management within the family are some of the central factors. Health-related competences and shared competences contain shared health beliefs, a mutual understanding of individual health motivation and barriers and health agreements in the family. These competences may make families capable of carrying out preventive health behaviours such as making healthy food choices and implementing healthy eating habits in their busy everyday lives, thereby determining families’ decision processes during food buying.

**Implications**

Our conceptual framework may be of interest to a broad group of researchers. *Consumer researchers* may use our conceptual framework to test how families acquire health-related competences specifically focusing on internal social interaction in families, and how these competences influence the family decision processes during food buying. These tests could be quantitative consumer studies such as self-administered questionnaires, as in Moschis and Churchill (1978), designed for children and parents respectively in order to compare their views (Nørgaard *et al.*, 2007). These tests could be conducted online via a webpage that includes an easy guide for how to answer as a compromise between the optimal face-to-face interviews and the more realistic and economic self-administered interviews. Based on these tests, future research could make a family segmentation distinguishing families in their communication patterns and/or shared health-related competences, and further develop the conceptual framework by, for instance, setting up a model for each segment. *Market communication researchers* may use our conceptual framework to test how effective food promotion or health campaigns involving a focus on the family dynamics are.
Psychology researchers may use our conceptual framework to test how children and families develop as consumers gaining health-related competences. Sociology researchers may use our conceptual framework to test how the family context including social interactions influences the family life and decisions. Human nutrition researchers may use our conceptual framework to test how families and children become healthier in their everyday life.

Our conceptual framework will also be useful to marketers in their development of food promotion targeting families with children, especially health campaigns. In order to meet some of the problems previous health campaigns may have had making them less effective in the long run, future health campaigns should focus more on insight about the specific target group of families consisting of both parents and children, but also which channels and executive elements are the most effective in reaching exactly these target groups (Attwood and Elton, 2003; Clark, 1997; Smith, 1997). Relevant insight about this target group is to recognise the family dynamics with open communication patterns in learning processes and decision making, thereby the context within which children act (Ellerton, 2004). Health campaigns should provide input to these family discussions with the purpose of making parents and children talk more about health issues at home and exchange perceptions, thereby encouraging word-of-mouth between parents and children. When targeting especially the children visual communication such as use of colours is important (Berry and McCullen, 2007). Health campaigns should use an integration of various channels in order to reach parents and children (Attwood and Elton, 2003). Children are typically early adopters of new technologies; therefore health campaigns should use new media like the Internet and Mobile phones combined
with traditional media such as television, packaging and in-store promotion. On the internet, kids’ clubs could be arranged encouraging word-of-mouth between children (Austin and Reed, 1999; Brown and Cantor, 2000; Calvert and Jordan, 2001; Kover, 2001; Montgomery, 2000; Moskowitz, Itty and Ewald, 2002; Tufte, 1999; Tufte and Rasmussen, 2003; Valkenburg, 2000). On packagings, colours, symbols, spokes characters, incentives and contests could be used. In in-store promotions, shelf location could be used to place healthy foods reachable by children, and health activities or events could be used to attract children’s awareness (Berry and McCullen, 2007). To reach parents a solution would be a combination of some new media like the Internet and the traditional ones like packaging and in-store promotion, as many decisions are made in the food stores (Nørgaard et al., 2007; Nørgaard and Brunsø, 2009). Among the executive elements, entertainment is important when targeting children; this includes interactivity and fun, but these elements should be combined with information about nutrition (Smith, 1997; Brown and Cantor, 2000). When targeting parents, information about nutrition could also be combined with some levels of entertainment. What is important for the information is that it is concise, thereby easy to understand and use among both parents and children (Nørgaard and Brunsø, 2009). It is necessary to be aware of that children are changing rapidly as consumers (e.g. their media use and crazes) in line with new media entrancing the market; effective marketing requires that continuous updates are carried out (Geraci and Nagy, 2004; Tufte, 2003). Moreover, health campaigns may be more successful if researchers and practitioners collaborate more intensively (Edwards, 2005). By influencing families to be healthier, marketers may demonstrate social responsibility to be reflected in the bottom line. Market communication targeted children will always involve ethical and moral aspects with the
purpose of protecting children which food companies should consider in their formulation of market communication strategies (Austin and Reed, 2003; Montgomery, 2000; Stanbrook, 1997; Tufte, 1999; Valkenburg, 2000). However, when promoting healthy food products, this should be a minor challenge.

Finally, our conceptual framework will be of value to society, as it outlines new ways of influencing families to make healthier food choices which will improve public health by, for instance, reducing obesity and overweight, curbing eating disorders and lifestyle-related diseases indicating unnatural and unhealthy attitudes towards food. The conceptual framework may also serve as guidelines for parents in the upbringing of their children. Today, many parents only spend little time with their children because of work and other activities (Belch and Willis, 2001; Tufte, 1999); when they do spend time with their children, it should be more intensively. Many parents should discuss and not only teach health-related issues more with their children. Also, many parents should be even more open to children’s motivation and barriers in food choices and they should encourage their children to be so too. This may make more families gain better insight in each other’s perspectives (John, 1999; Nørgaard and Brunsø, 2009) and gain shared understandings of health as an umbrella for individual motivation and barriers in food choices, which there still should be room for in order to develop and maintain individual identities.
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CHAPTER 7: GENERAL DISCUSSION
SUMMARY, CONCLUSIONS AND NEW CONTRIBUTIONS

What has my PhD project taught me and what are the new contributions?

Research question 1

The findings in article 1 show that decision-making during food buying is often a joint activity involving both parents and children when the children are aged 9 to 12, characterised as Tweens. This indicates that it is important to include both parents and children in a family food decision-process framework. The findings also indicate that our modification of Jensen’s (1990) family model is useable as a theoretical framework in food buying when focus is on children as influencers.

The article contributes new insight showing that children participate actively in their family’s food buying and help out doing various tasks at home and in supermarkets. These tasks are primarily practical and supportive (e.g. pushing the shopping cart), but not labour intensive; while parents do the rest (e.g. comparing food products). This indicates that parents manage the purchase act, which is no surprise, leaving children with more time for browsing.

The article supports previous research about children influencing their family’s decision-making (Atkin, 1978; Belch, Belch and Ceresino, 1985; Caruana and Vassallo, 2003; Ekström, 1995; Foxman, Tansuhaj and Ekström, 1989; Jenkins, 1979; Lee and Beatty, 2002). Children exert
influence in all decision stages in the family’s decision process during food buying, but most on initiation and choice, which supports previous studies (Belch et al., 1985; Lee and Beatty, 2002). This article also supports previous findings concerning the fact that children’s influence varies across decision areas in the decision process (Belch et al., 1985; Foxman et al., 1989; Jenkins, 1979; Lee and Beatty, 2002). The article contributes new insight about these decision areas: children have most influence on small and easily prepared meals, food that is easy to prepare, unhealthy food (e.g. sweets) compared to healthy food (e.g. fruit, vegetables and fish), and fruit more than vegetables when it comes to healthy food.

Children’s active participation in and help during food buying determine their influence. The more they help, in particular with preliminary tasks like ideas for food products to buy, the more influence they gain. The children realizing this are therefore the smartest ones as regards getting what they want. These findings provide new insight to research about child-specific reasons for children’s influence (Grønhøj, 2003; Hansen and Halling, 2002; Jenkins, 1979; John, 1999).

**Research question 2**

Many decisions are made in the supermarket or other food stores when families are out shopping for food; often food packaging is used to compare food products when standing in front of freezers, coolers and shelves in supermarkets. Tweens participate only in some degree in the activity of comparing food products, supporting the findings in article 1.

Viewing consumers’ use of nutritional information in a family context, focusing on both tweens and parents as active parties, contributes new
insight. Not only are value conflicts with the health-pleasure trade-off and necessary compromises intensified when children are added to the family, as supported by Connors, Bisogni, Sobal and Devine (2001), also new individuals (i.e. the children) participate in the decision processes together with their parents, as supported by findings in article 1, requiring labels to be targeted at both adults and tweens.

Our ethnographic study finds that families’ actual use of nutrition labels is infrequent, which supports previous research about consumers in general (Grunert and Wills, 2007). The results contribute new insight finding that tweens do not use the labels at all but ask their parents instead.

Health is an issue which many families want to take into account in their food choices, at least according to parents. The hall test results show that parents’ health consciousness explains their preventive health behaviour focusing on the use of nutritional information on food labels positively. However, parents and their tweens do not always share perceptions about the priority of health in the family. This may, among other things, be a result of parents not discussing health with their tweens and not actually performing preventive health behaviour frequently by overtly using nutritional labelling; this provides new insight. The results support Elverdam and Sørensen (2003) in finding that the perception of health differs across and within families indicating a need for segmenting families in order to understand their health behaviour better.

Parents’ doubts about their health knowledge may make them refrain from performing preventive health behaviour using nutritional information and from discussing with and teach their children about health and use of nutrition information. This doubt makes parents’ understanding of nutrition
information difficult and time consuming. The hall test results show that parents’ problems related to amount of information, technical information and energy distribution explain their use of nutritional information on food labels negatively. In our qualitative findings, tweens did not display obvious problems, because they mostly did not use nutrition information. This all contributes new insight elaborating on previous findings about problems using nutrition information within the issues of health ability and knowledge supplemented with a tweens aspect (Grunert and Wills, 2007).

Based on input from the qualitative study, and input from a major international food company, three new versions of a nutritional label were developed in order to meet problems perceived by consumers.

The new labels were tested against the traditional one among parents. Results showed that parents’ preference for nutrition labels depends on the presentation style. The more problems with the general understanding of nutritional information, amount of information, technical information and energy distribution parents perceive, the more likely they are to prefer food labels showing a table with more visual elements, i.e. the label alternatives with five circles and four blue ellipses. This indicates that label information should be made more accessible to reach consumers with low motivation and ability. Furthermore, this shows that the processing theory framework is useable as a theoretical framework in a family context indicating that motivation and ability influence the route activity. It also indicates an interest-ability trade-off showing that even though families may want to be healthy they are cut off from being so because of limited abilities.
The actual settings using ethnographical methodologies combined with a hall test contribute new insight as a contrast to previous findings about self-reported label use (Grunert and Wills, 2007).

**Research question 3**

Article 3 contributes to the understanding of the family influence process in a food buying context, which supplements previous research with the influence outcome as the main focus. This contributes to a more comprehensive understanding of family decision-making during food buying, the health-pleasure trade-off, and how the final food choice is made beyond the study of adult food choices only.

Our study provides new insight into the types of conflicts that arise during family food buying and the reasons for the conflicts. Different food preferences and different food-related beliefs, such as health beliefs among family members, generate conflicts, supporting and supplementing Connors *et al.* (2001) and Drichoutis, Lazaridis and Nayga (2006) regarding value conflicts and health-pleasure trade-offs in families.

This research also contributes new insight into conflict solution during family food buying, e.g. about tweens and how they communicate with their parents in order to achieve influence on food choices. Most families apply a very open communication style during food buying allowing room for all preferences and opinions, which could be classified as belonging to a ‘concept orientation style’ with both pluralistic and consensual communication patterns (cf. Figure I) according to the studies by Moschis (1985), Rose, Boush and Shoham (2002), and Caruana and Vassalo (2003).
However, parents still have the last say as a result of their being in charge of shopping and cooking.

Also, we found that in a food buying context it may not make sense to distinguish tweens’ influence techniques from parents’ response techniques, as in Palan and Wilkes (1997); because there is no system to who provides the first idea and consequently who is to respond. Tweens and parents alike use techniques like knowledge and experience supporting the ‘expert use technique style’ in Palan and Wilkes (1997).

Our research supports Marquis (2004) in finding that young tweens (aged 10) use persuasive techniques such as expressing opinions and stating preferences. However, in our study the tweens do not use begging and pestering, only the younger siblings (younger than 10 years) do. Our research also supports Marquis (2004) in finding that young tweens use emotional techniques like being nice and helpful.

Nevertheless, one of our most interesting findings is tweens’ use of the help easing food buying technique, which supplements findings in article 1. It also supplements Palan and Wilkes’s (1997) findings about matching influence strategies to parents’ decision-making style. Tweens realizing this have developed a cleverer competence that gives them more influence than other tweens. In general, the tweens in our study are verbal in their influence, which is something they develop with age according to John (1999). John (1999) also finds that children learn which techniques are the most effective as they grow older; in our research the tweens have indeed learnt this and use them.
As opposed to negotiation, as dealt with in the study by Palan and Wilkes (1997), one technique seems more widespread in a food buying context: ‘convenience use’ and conflict avoiding. This may be a consequence of families’ busy everyday lives where they want food shopping over and done with quickly. This is somehow linked to tweens’ use of the help easing food buying technique. Family members do not spend time discussing the various suggestions or beliefs, e.g. health issues, but find ways to avoid this. Parents do not have the energy to discuss all conflicts in depth and often choose to postpone discussion for situations where there is more time. This supports studies about conflict avoiding being used in families, like e.g. Kirchler's (1993). Different preferences do not lead families to resort to compromise as in Park (1982); instead they sometimes choose both alternatives. For instance, when the tweens want mackerel with sugar, their parents put off the conflict for a later point in time giving the children what they want in order to maintain harmony, supporting Lake, Rugg-Gunn, Hyland, Wood, Mathers and Adamsom (2003) and Holm (2005). This illustrates the health-pleasure trade-off in families, and how children use smart influence techniques in order to get what they want, which is not always healthy food. When children help parents by easing food buying, parents give something in return by letting children have what they want. Nevertheless, children accept if their parents have particular strong beliefs about, for instance, health.

**Research question 4**

Families’ preventive health behaviour consists of, for instance, collecting information about nutrition and choosing healthy food products as a part of the decision process during food buying. Families do not always choose
healthy food products, and children influence the choice of many unhealthy food products, as found in article 1. Nor do families always use nutrition labels, as found in article 2. These limited or even missing activities in preventive health behaviour are, among other things, due to problems in families’ understanding of standard nutrition labelling, as found in article 2. This indicates that health-related competences are an important determinant in families’ preventive health behaviour, supporting previous research focusing on adult consumers in general (Grunert and Wills, 2007; Jayanti and Burns, 1998). As a new extension, this also indicates that the health-related competences may be relevant for families’ decision-making during food buying.

The article suggests a framework that supports the integration of cognitive and social dimensions in the consumer socialisation and learning process as put forward by Moschis and Churchill (1978). However, our framework provides new insight in consumer socialisation and learning by integrating various aspects such as a food buying perspective, health aspects, dual influence social interaction (influence from both parents and children), family everyday traditions and practices, and the family’s shared health-related competences.

The framework suggests that families achieve these health-related competences in a learning process or socialisation process. In this process, social interaction and open family communication patterns in the family particularly between parents and children, as found in article 3, is essential. Social interaction in the family is considered as a dual influence process, i.e. family dynamics, as found in article 1; it includes listening, knowledge sharing, communication, direct influence attempts and response, team
work, discussions of individual learning properties and knowledge management, as based on the findings in article 3. Here parents and children are equal as part of the concept-oriented communication patterns in families (Moschis, 1985; Caruana and Vassallo, 2003). This extends the use of the concept of family communication by putting it into a health perspective in consumer learning. Our framework focuses on health by including health motivation and health consciousness as determinants in the learning process as well as health-related competences (health knowledge, health ability and health attitude) resulting from the process. In this way previous research is extended by putting the concepts of health motivation, consciousness and ability into a new perspective (Jayanti and Burns, 1998). Furthermore, our framework adds everyday traditions and practices in the family supporting the importance of the family context as a social setting in the learning process (Christensen, 2004; Hedegaard and Fleer, 2008).

The article suggests that a family's shared competences are important in addition to the individual family members’ competences. More precisely these shared competences consist of a deeper insight into individual perspectives, shared health beliefs, a mutual understanding of individual health motivations and barriers, and health agreements in the family. Interaction implies that parents and children learn from each other: they learn more about each other’s perspectives, preferences and needs. Previously, parents used to make almost all decisions by themselves leaving them with a tough job to recognise all family members’ preferences and needs (Grønhøj, 1998; Kirchler, 1988; Lerouge and Warlop, 2006; Tufte, 1999). Interaction also opens an opportunity for parents to discuss food issues with their children. The shared competences enable families to integrate and maintain healthy food choices and healthy eating habits at the
same time solving conflicts like the health-pleasure trade-off as well as maintaining harmony, but in addition they also work as an umbrella for stronger individual health perspectives, preferences and behaviour (Connors et al., 2001; Drichoutis et al., 2006; Edwards, 2005; Elverdam and Sørensen, 2003; Holm, 2005; Lake et al., 2004). This extends previous views on only individual learning properties or individual consumer competences.

Because of the intensive food promotion targeted both parents and children, it becomes even more important that the family possesses the consumer competences required to think and act in a healthy way.
LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

What would I do differently if I were to start my PhD project today?

This question will be answered in the following presenting a mixed discussion of limitations, suggestions for adjusted research areas and for future research including contents, methods and analyses for each article in the PhD project.

Research question 1

The first article underscores the importance of looking at family food decision-making as a joint activity where children participate actively and gain influence. Future research may use the framework outlined in this article for structuring research on family decision-making. Extensions of this article’s framework may include an investigation of the relation between children’s consumption of specific food products and their influence on these in order to uncover whether their influence does indeed result in unhealthy eating habits. Other extensions may be an investigation of other reasons for children’s influence. Furthermore, future research can use our findings as a framework in studies whose focus is on one specific decision stage in the overall family decision process. This article underscores the gains such as multi-perspective results of using mixed-method approaches; such a mixed-methods design is recommended because the approaches combined make a stronger design. Finally, the article shows that parents and children do not always agree on the extent to
children’s influence, indicating the importance of listening to both parties in research on family dynamics and processes involved in everyday food buying, supporting previous research (Foxman et al., 1989).

Regarding the data collection methods, the pre-test of our questionnaire in the survey generally showed that the families found the self-administered questionnaires appropriate and the children found them fun to fill in, but that the questionnaires are too long. Furthermore, the children were able to answer the questionnaire without help from their parents. Some children, though, found it difficult to answer the food buying questions and to recall how often things happen, which supports previous literature (Andersen, 2000; Andersen and Kjærulff, 2003; Bøving Larsen, 2002; Gfk Danmark, 2004; Glahn, 1992; Mayes, 2000; Melzer-Lena and Middelmann Motz, 1998; Ottosen, 2002; Scott, 2000). Parents’ help included that they read the questions aloud to the children; they explained the meaning of the questions; they explained how, but not what, to answer; and they reformulated some questions. This result indicates that the most optimal interview with children of this age would be a personal face-to-face interview, where the interviewer, rather than the parents, can help children understand the questions. However, it is much more time consuming and expensive to do personal interviews compared to postal ones, which is why we chose the latter method.

Another data collection technique option might have been online questionnaires, as children in this age group use computers and the Internet at home (Tufte, 2003). The children may even find an online study fun to participate in. This approach may make the distribution of the questionnaires to the families cheaper, but it may be more expensive to
setting up the questionnaire at, for instance, specific websites developed for the project. The online approach furthermore allows setting up a fun and child-friendly online guide to complete the questionnaire. This procedure may also create an opportunity to collect cheap data from other countries than Denmark for comparison across countries. In our pre-test, the children gave ideas for improving the questionnaires with a focus on including cartoons or more pictures, and letting the children complete the questionnaire using a computer.

By using LISREL instead of traditional regression in SPSS, future research may improve the statistical analyses, for instance by investigating children’s influence in the various decision stages and areas and the relation to explaining factors like children’s competences. LISREL allows large models but requires a solid a priori insight in the model structure and hypotheses based on previous research (Blunch, 2000; Bollen, 1989). Another alternative for measuring the factor structure in the framework is AMOS (Blunch, 2000).

**Research question 2**

*Content.* Future research may use the findings in the second article to further investigate how consumer competences, such as information processing skills, influence parents’ and children’s use of various food products. The findings could also be extended by differentiating between segments such as strategic, cued and limited information processors (as in Roedder, 1981), and linking these to the outlined framework to uncover differences in the various segments’ use of nutritional information and choice of food products. Another extension of the hall test could involve
children in the test of the four nutritional labels. Previous research outlines three objective methods of evaluating how packaging works with children: 1. watch and observe their behaviour in the retail environment; 2. ask them questions and listen to their answers; and 3. change the packaging and measure the result (Clark, 1997). We did 1. and 2. asking both parents and children, while we only did 3. with parents leaving this test with children for future research.

Recruitment. In the qualitative study, our plan was to recruit about 20 families. As ‘no specific rules’ exist for how many cases qualitative studies require, a redundancy or satiety criteria was used instead. Redundancy occurs when the same statements are repeated 80% of the time. This means that we continuously kept track of the satiety point closing recruitment when enough information had been collected and when we estimated that more cases would not add anything decisive (Neergaard, 2001). However, the recruitment of families was not easy, not because of a lack of interest or motivation among families but more because of practical everyday issues making it testing for families to invite us home in the hours before dinner when everybody and particularly the children are tired.

Previous research supports the choice of schools to get access to children at a particular age and to start out approaching children in class before visiting their families. This has the effect that the children are pleased to see the researchers again at their home and are happy to be one of the ‘selected children’ whom the researchers visit (Banister and Booth, 2005; Tufte, 2000). Ekström (1995) and Palan and Wilkes (1997) use a three-step procedure, as in this PhD project, but these studies use school class lists and contact families based on the lists; it may not always be possible to get
permission to look through school registers. We found that another practicable alternative was to talk to the principal and the class teacher. Recruiting families through schools was chosen because it is considered easier to gain access to families this way, and it ensures that not only the parents but also the children in question want to participate. Alternative procedures might be attending a parent meeting or a school management meeting to present the project to the parents; or a piece about the project could be written for the school paper.

Fish consumption and families being light-users of fish products were chosen for both the qualitative and quantitative studies because of the relevance for the large Danish research project KITCHEN, which this PhD project’s empirical studies were part of. However, this may have influenced results, and it might be advantageous for future research to recruit a broader group of families in order to obtain a more representative group of respondents in the quantitative test.

For practical reasons, the families that took part in the qualitative study were chosen from either the Aarhus or Vejle areas, Denmark; this may also have affected results. In hall tests, future research might distribute recruitment over three or more locations, as in McEwan (1997), in order to obtain a more representative group of respondents; the recruitment in this PhD project took extra time because of the specific family criteria, and a two-location solution was chosen based on economic considerations.

Data collection. Future research may improve the qualitative part by increasing triangulation, following each family for a longer period of time including more visits, using more visual and other aids like video-recording, photos etc. (Hedegaard and Fleer, 2007).
Diaries could be used as a supplement in the period in between visits the aim being to let families make notes about their food choices and eating habits each day. This might reveal aspects that did not come up during the family visits (Fraser, 2004).

The inclusion of children’s own drawings and vignettes was appropriate in some situations but not in others; this was therefore adapted to the situation. However, drawings and vignettes can be a good addition to the other techniques and might have been used more systematically (Banister and Booth, 2005; Christensen and James, 2000; Dybdal Jensen, 2001; Ekström, 1995; Fraser, 2004; Kampmann, 2000).

In the qualitative study, Dictaphones made a good memory support back-up to our notes when analysing and interpreting the collected data. However, Dictaphones proved a challenge in the supermarkets because of all the background noise which made transcription difficult and time consuming. An alternative to Dictaphones is video records allowing the researcher to re-observe the families’ behaviour without them being present, while Dictaphones only record voices. However, video records perhaps does not allow participant to be relaxed and they may distort the atmosphere, for example during family dinner, whereas a Dictaphone is more discreet. The researcher must take heed when using video recording and get the families’, both parents’ and children’s, acceptance prior to commencing the study (Christensen, 2000). Previous research has good experience with the use of Dictaphones in studies with children (Banister and Booth, 2005).

Another alternative or maybe a supplement to Dictaphones is single-use cameras when visiting families to take snapshots of supermarket and kitchen situations. Before taking any photos, the researcher must explain
the intended use to the families and ask their permission to take pictures and use them. Another option is to have the children take photos using disposable cameras to support the research. This makes it possible to obtain children’s perspectives on the situations under study, but it can also create conflicts in the relation to the photographed persons (Staunæs, 2000). Previous research has been successful in letting children take photographs related to the research area (Banister and Booth, 2005).

Finding private surroundings with minimal interruptions in an environment where children especially feel secure is important when carrying out participant observation studies (O’Kane, 2000). The data collection in the supermarkets proved to be somewhat of a challenge because we needed to ensure that the children felt relaxed and secure, because they are outside their home and because of the noisy environment and the interruptions. Here, it would have been valuable to have had the time to strike up a closer relationship with the children.

Furthermore, the qualitative study would have benefitted from having *two interviewers and observers* instead of only one. This would have made it easier to monitor both parents and children during the family visits and also of to achieve a more objective assessment of the observed as various researchers contribute their views. Future research should be aware of this.

As regards the hall test, the questionnaire pre-test showed that *personal guidance* in the face-to-face interview should be considered as the respondents needed assistance to understand what to do and how to answer.

*Analyses.* Moreover, one could argue that more items or variables would improve the statistical analyses and would circumvent problems when
using latent variables in the analyses; however in the situation at hand, it was a matter of striking a balance between obtaining all the relevant information and designing a short questionnaire as the test was a hall test that only was supposed to last a few minutes compared to a survey. Future research may, as in article 1, also improve the statistical analyses by using LISREL or AMOS instead of traditional regression and analyses of variance in SPSS (Blunch, 2000; Bollen, 1989).

Research question 3

Future research may use the findings in article 3 to further investigate family communication patterns and families’ use of influence techniques, especially concerning health issues.

Our findings could be extended by investigating parents’ and children’s awareness of their own use of influence techniques and that of their “adversary” in order to find out how strategic they, i.e. parent and children, are in their influence attempts. Future research might also investigate preference differences, in particular as regards food quality beliefs such as taste, health, convenience, production techniques, price, own experience, and/or new information (cf. the Total Food Quality Model, see Grunert, Hartvig Larsen, Madsen and Baadsgaard, 1996), how these result in conflicts, and whether children use influence techniques based on food quality beliefs. Future research could investigate age and gender differences in children’s use of influence techniques during food buying, thereby further developing Kirchler (1993), John (1999) and Marquis (2004). It seems that girls tend to be more strategic than boys, for instance, by using the help easing food buying technique. Furthermore, future
research could investigate other reasons for the use of various influence techniques. Finally, regarding the methods used, please turn to the discussion of the qualitative studies above under Article 2.

**Research question 4**

The framework developed in the fourth article is based on a literature review of previous research and sums up the essence of the area of interest. However, the framework is comprehensive and may be modified in future research aiming at specificity. Examples of more specific research areas within this framework are: a test of how children and families develop as consumers gaining health-related competences, a test of how the family context, including social interaction, influences the family life and decisions, a test of the effectiveness of food promotion or health campaigns involving a focus on the family dynamics, and a test of how families and children become healthier in their everyday lives.

Future research could extend the framework by segmenting families distinguishing them in their level of internal health-related social interaction, extending the research of family internal communication in Moschis (1985) and the findings in article 2 about differences in health perceptions across and within families, as supported by Elverdam and Sørensen (2003).

As this article is only conceptual and does not test the framework empirically, it is up to future research to do. Empirical studies testing this framework could be qualitative extending the framework including more details and/or adopting the framework to specific research purposes. Empirical studies testing this framework could also be quantitative like
questionnaire surveys, which could be conducted online via a webpage with an easy and interactive how-to guide as a compromise between the optimal face-to-face interviews and the more realistic and cost-effective self-administered interviews. Empirical studies, qualitative as well as quantitative, should involve both parents and children for subsequent comparison of their perceptions. LISREL may be used for the analysis of the quantitative data; though this may require preliminary tests of the relations using simpler statistical software like SPSS (Bollen, 1989).

Collaboration

In general, it may take more interdisciplinary research with collaboration between, for instance, consumer research, industrial or retail research, sociology, psychology, human nutrition research and educational research to help families become healthier food consumers (Edwards, 2005).

Ethical considerations in research involving children

*How well does this PhD project comply with the ethical guidelines for doing research with children?*

The 10 ethical guidelines, dealt with in Chapter 2: Methodology, will be discussed below in the context of the research done in this PhD project (Kampmann, 2000).

*Ad 1: The aim of the research project.* This thesis is perceived as being of interest to research as well as families in that it focuses on how families buy food and how to make these food decisions healthier; and in that it is not a commercial project whose only objective is the promotion and sales
of an ever-increasing volume of unhealthy food to the children. However, food is usually not a core area of interest to children which may indeed influence their level of commitment. On the other hand, our general impression is that the children felt important as persons when we as researchers asked their opinion.

*Ad 2: Costs and expected benefits.* Our general impression is that the children enjoyed participating in the project and also relished being important as persons, which exceeds the time they spend on their participation.

*Ad 3: Privacy and confidence.* Fortunately, we did not experience situations where children imparted information that required us to bring to the attention of a public authority. This consideration may, however, be of less importance in this PhD thesis researching a low sensitive subject such as family food buying.

*Ad 4: Recruitment, inclusion and exclusion.* When recruiting children from school classes in the qualitative studies, the children decided themselves whether they wanted to participate and later consulting their parents. We did, nevertheless, experience some awkward situations, as a number of children where living in a children’s home and not together with their parents. The school principal had not informed us about this a priori but we managed anyway without upsetting any children. We called the children’s home and talked to their contact persons in order to find a solution.

*Ad 5: Project funding.* The most important advantage of using participant observation is the extensive personal interaction with the subjects of the study. Spending time with the subjects allows them to feel relaxed and
comfortable in the presence of the observer (Zikmund, 1997). Our impression is that the time resources were not completely sufficient for the ethnographic studies, which ought to have been carried out over a longer period of time with more visits to each family. More time could have given us the opportunity specifically for the individual interviews with parents and children, getting to know the children better and ensuring that the children would feel relaxed and comfortable in our presence, which would produce even better data.

Ad 6: Assessment and revision of the aim and methods of the project. To some extent we gave parents and children an opportunity to influence planning of the ethnographic studies in that they had influence on when we could visit them (month, week, and day) and also for how long we could stay in their home.

Ad 7: Information to children and parents. A priori all participating parents and children received written information about both the qualitative and quantitative empirical studies as well as a contact person details. The information was made intelligible to both parents and children; also it included pictures to attract the children’s attention so that they would not feel that this was only meant for their parents. Handing the children a folder at school, we experienced that they felt important as persons as they received the information before their parents.

Ad 8: Participation acceptance. This was one consideration that had our utmost attention; we believe that we were successful in the sense that the children had the opportunity to reject participation if they did not feel like joining the study. Our general experience is that children in this age group, about 9 to 12 years, like and are curious about participating in research
studies as it makes them feel important as consumers. Therefore, we also to some extent accepted if during the interviews and observations children sometimes wanted some time alone. In the ethnographic studies, we talked to each child at school about their interest in participating and asked them to discuss it with their parents. Only children expressing a certain amount of interest in participating received a folder, and a number of folders were left at the school for the children to pick up later if they should change their minds. If the children did not want to participate, they could simply tell their parents not to sign the acceptance or just not give the letter to their parents. In the telephone recruiting, parents were asked to discuss their child’s interest in participating with him or her so that the parents would not decide for them. One problem by letting families confirm their project participation may be that they do not really act naturally and relaxed when taking part in the ethnographic studies; however this turned out not to be a problem as the visits took place on weekdays with all the ensuing chaos. It is our impression that it is easier to obtain parents’ acceptance if the principal has accepted the recruiting process at school, if someone close to the family recommends us and participation in our project, and seeing that our project is not commercial.

Ad 9: Presentation. One limitation of the empirical part of this PhD thesis is that parents and children did not have the opportunity to read the main conclusions of the project. This would have proved the objectivity of the interpretation of the collected data also showing the families and their opinions due respect, all to close the project properly.

For instance, it would have added to the proper closing of the project to visit the children at school after carrying out all the family visits. Here we
could have thanked them for letting us come to their homes and could have solicited supplementary remarks and asked them about issues which had not occurred during the visits. This would have been a good way to show the children one last time that we appreciated the time they spent on us. Since, contrary to the expectation our recruitment ended as a mix of different procedures including snow-balling instead of only being school-based, this was not considered as an appropriate ending in this project.

Ad 10: Consequences for children. This thesis had a particular challenge, namely the design of empirical studies to obtain children’s viewpoints as a supplement to those of their parents. This took many a priori considerations and preparations Nonetheless, we experienced that involving children successfully was more difficult than anticipated. Particularly the ethnographic part, proved a challenge; sometimes it was even difficult to achieve a response from the children when parents and children were together. Therefore, the project may in some respects have produced limited understanding of children.

Overall, we can conclude that we met the ethical guidelines for research with children, though some areas could be improved.
IMPLICATIONS FOR MARKETING, POLICIES AND SOCIETY

Implications for marketing

*How can marketers and food producers effectively promote healthy food targeted children and their families?*

In their food promotion marketers may benefit from the findings in this PhD thesis – especially health campaigns targeted families with children.

The general message to the target group should be: It is cool, fun, easy and pleasant to be healthy!

Marketers may benefit from the findings in *the first article* when targeting their food promotion at families. First of all, the insights indicate that marketers should target their food promotion to both parents and children, as family decision-making is a joint activity with both parents’ and children’s active participation and influence. As a support to this, previous research suggests that a mother changing her own motivation and behaviour may not necessarily lead to an improvement of her children’s diet (Alderson and Ogden, 1999). Therefore, food and health promotion should be targeted at both parents and children.

As many decisions are made at the food stores, and as both parents and children participate actively at the purchase act stage in the buying process, marketers should *focus on in-store promotion* in order to reach families and
children. However, research on in-store promotion of healthy food messages targeted to children is rather limited (Berry and McCullen, 2007).

Insight in children’s influence in the idea generation and choice stages, but also insight showing that children often spend time browsing in food stores when helping their parents pick out food becomes boring, exposing children to new ideas may be useful in this respect. This insight may be used to focus on attracting children’s attention and providing children with inspiration and healthy food ideas, with the purpose of affecting children’s food preferences and choices and making children bring these ideas to their parents’ attention thereby influencing them to buy the products in question. Here marketers should concentrate on certain food products. They should focus on small and easily prepared food products (e.g. fruit and snacks), because children’s influence on especially these food products is high. In order to reach the parents, marketers should focus on total meal solutions, as parents have the overall say in the general decision stage; also, marketers should focus on more labour intensive food products (e.g. meat) as parents decide most regarding choice of these food products.

Especially in the promotion of the small and easily prepared food products to reach children, marketers should first of all integrate various activities (Attwood and Elton, 2003). These activities should meet children’s interests and crazes; and focus in the health messages should be on coolness/popularity and fun. In-store layout is one marketing activity that might be used. For instance, it might be a good idea to create a snack section where children could go and hang out when not trailing after their parents; this may also make it easier for parents to find their children again.
All POS material in this section (e.g. shelf fronts, light displays, other displays, coolers, freezers) should appeal to children and should include cues with health messages. For instance, shelves should be mounted so that the healthy snack products are within children’s reach (Berry and McCullen, 2007). *In-store monitors could be set up* in the snack section to show short spots (e.g. cartoon spots) of children eating healthy food and snacks, health jargon with cool terms. This could teach children health etiquette using cool aspects and terms for social interaction with peers, which children can bring to school and other social settings with peers thereby triggering word-of-mouth among children. Previous research finds that videos with nutrition messages may have a positive influence on children’s short-term food choice (Bannon and Schwartz, 2005); as these messages are designed to stick for the duration of a visit to the food store, the short-term effect may be successful. *Events* should be added by creating a platform with child-related activities. For instance, an endorser could demonstrate the preparation of a healthy snack meal using elements of entertainment and interactivity by involving children actively and by letting them prepare a small taste sample snack meal together with other children.

As regards parents, the health message focus should concentrate on *easiness/convenience and pleasantness* and should provide parents with *a foundation of health attention and knowledge* to be used in controlling/gate keeping their children’s ideas. These aspects could be implemented in the in-store design including the children’s snack section as parents will typically pick up their children when they have finished their food shopping. For instance, the endorser could also try to influence parents providing then with simple cooking tips and recipes.
Marketers may benefit from the findings in *the second article* by focusing on the development on *food label designs* as important for the sales of healthy food. This may provide a strong case as food packaging is often used when making choices in food stores; but as supported by article 1, children rarely participate in the comparison of food products using packaging cues, which may be due to the fact that the designs are not targeted children. Marketers should therefore focus on developing *food packaging* to include children as its target, especially for products in the snack section. The packaging design should attract children’s attention and interest enabling them to use cues, information, pictures as well as other executive elements in order to influence their parents to buy the products. For instance, colours, spokes characters (e.g. Kellogg’s ‘Tony the Tiger’ and Co-Ro’s ‘Mr. Suntop’), shapes and themes may be effective ways of communicating with children (Berry and McCullen, 2007; Marshall, Stuart and Bell, 2006).

As article 2 reveals that children do not pay much attention to information about nutritional content, and parents find the standard nutritional labelling difficult to understand and use. Nutritional information should be presented in a way that is *faster, easier and more appealing for parents as well as children*. This could be achieved by using a *limited amount of nutritional information, a less technical presentation form and more visual elements like colours and symbols* primarily depicting energy distribution. Visual communication such as visual cues is a powerful tool in influencing children’s food choices as children’s ability to engage with a product through text is less developed than that of adults (Berry and McCullen, 2007). Research finds that simple nutrition labelling information influences children’s choice of low-fat healthy food positively in a school cafeteria.
setting (Neal and Langnäse, 1998); it may therefore also influence them in a food store setting.

Marketers do indeed face a big challenge regarding the design of easily intelligible nutrition labels which will also attract the attention of parents as well as children. This challenge is especially interesting after the recent and widespread introduction of a new nutrition label across a number of countries worldwide. In Europe, this label has been criticized, for instance, by the Danish Consumers’ Advisory Council for complicating comprehension, because it uses Guideline Daily Amounts rather than “per 100 grams”, which consumers are used to (DR TV-Avisen, 15.03.09). The recent introduction of the Nordic nutrition label ‘Noglehullet’ may simplify families’ and children’s food choices by meeting some of their problems of distinguishing between healthy and unhealthy food alternatives by providing a visual cue.

Marketers may benefit from the findings in the third article in their development of food promotion, particularly health campaigns. With the aim of supporting various family members in their attempt to convince other family members to buy certain healthy food products, marketers may find ways of supporting children as well as parents in their influence process. Especially children may gain increased influence over food choices in their family if they get support and inspiration to help and ease their parents’ food buying process. Marketers could use this to design food promotion material in a way that arouses children’s interest in health making them demand healthy food products. As previous research finds that some parents feel that it can be stressful and exhausting to bring and to involve children in food choice activities, food stores should be designed to
make the shopping experience pleasant for families (Pettersson, Olsson and Fjellström, 2004), for instance by setting up areas and activities for children as described in the marketing implication section in article 1.

Finally, marketers may benefit from the findings in the fourth article. Our conceptual framework will be useful to marketers in their development of food promotion targeting families with children, especially health campaigns.

In order to meet some of the problems that previous health campaigns may have encountered making them less effective in the long run, future health campaigns should refrain from scaremongering and raised fingers. Instead they should focus more on their specific target group of families consisting of both parents and children, as well as on which channels and executive elements are the most effective in reaching these particular target groups (Attwood and Elton, 2003; Clark, 1997; Smith, 1997).

Relevant insight about this target group is to recognise the family dynamics with open communication patterns in learning processes and decision-making as discussed in article 4, that is the social context within which children act (Ellerton, 2004). Health campaigns should provide input to family discussions with the purpose of making parents and children talk more about health issues and exchange perceptions, thereby encouraging word-of-mouth between parents and children. In order to reach parents and children health messages should focus on the aspects of coolness/popularity, easiness/convenience, fun and pleasantness of being a healthy consumer.
Health campaigns should integrate various channels in order to reach parents and children (Attwood and Elton, 2003). This means that other marketing activities should be added to in-store promotion and packaging design, as described earlier. Children are typically early adopters of new technologies; therefore health campaigns should also use new media like the Internet and mobile phones.

On the Internet, kids clubs could be set up encouraging word-of-mouth between children (Austin and Reed, 1999; Brown and Cantor, 2000; Calvert and Jordan, 2001; Kover, 2001; Montgomery, 2000; Moskowitz, Itty and Ewald, 2002; Tuft, 1999; Tuft and Rasmussen, 2003; Valkenburg, 2000). Online clubs for children and their parents could also be used to spread information about products and health aspects to encourage word-of-mouth between children and parents. Also, video clips of children cooking with their parents would be an option to bring children and parents closer with cooking tips and simple recipes to ease their busy everyday lives. Using the Internet as a marketing channel primarily directed for use at home, is appropriate here, as health discussions should start at home before families go to the food stores and make their final food choices.

When targeting children, one of the important executive elements is entertainment; this includes interactivity and fun, but these elements should be combined with information about nutrition (Smith, 1997; Brown and Cantor, 2000). When targeting parents, information about nutrition could also be combined with some entertaining aspects. What is crucial about the information is that it must be concise, meaning easy to understand and use for both parents and children, as found in article 2.
In general, it is necessary to be aware of children’s rapid changing as consumers (e.g. their media use and crazes) in line with new media entering the market, cf. the introduction. Effective marketing initiatives such as in-store promotion and packaging design therefore require *flexibility and continuous updates and modifications*, (Geraci and Nagy, 2004; Tufte, 2003).

In-store promotion may be an expensive short-term solution for retailers, as it will not pay off immediately, but it is a necessary long-term investment in order to reach families and children. However, this short-term investment does not have to be that *expensive*, as the in-store promotion may be designed for flexibility starting with a standard solution with build-on options. Close collaboration with advertising agencies and printing houses could also make in-store promotion less expensive.

**Ethical considerations for marketing targeted children**

Market communication targeted children – especially food promotion focusing on unhealthy food – will always involve *ethical and moral aspects* with the purpose of protecting children, which food companies should consider in their formulation of market communication strategies (Austin and Reed, 2003; Cross, 2002; Montgomery, 2000; Stanbrook, 1997; Tufte, 1999; Valkenburg, 2000).

**Food industry responsibility**

Food companies must consider ethical and moral aspects in their marketing strategy plans, especially when targeting children. Even though in many
ways children may be perceived as competent consumers, they are still only kids that need protection.

Food promotion material should be created on an acceptable level bearing children in mind, and the food industry should make healthy eating easy. As a consequence, companies should display social responsibility; but since food promotion follows the overall purpose of selling, social responsibility might not always be a top priority (Barwise, 1997).

When promoting healthy food products, the ethical and moral guidelines is one of the lesser challenges. Insight in families’ food buying and especially children’s role in food buying may also be used positively in health campaigns to influence families and children to choose more healthy food products.

Marketers may benefit from helping families become healthier in the respect to social responsibility that may be an overt bottom line bonus in a long-term perspective. This may give them a clean conscience and a better reputation. Companies just have to realise this, which may be hard in situations of financial crises as we see now.

Examples of demonstrating social responsibility are:

- targeting health messages not only at parents but also children by focusing on small and easy prepared meals and food products and on in-store promotion, as suggested in article 1;

- development of more concise nutritional information on food labels, as suggested in article 2;
- design of promotion material, particularly health campaigns, in a way that will arouse children’s interest in health and make them demand healthy food products, and that also support and inspire children in ways to help and ease their parents’ food buying process, as suggested in article 3; and

- encouragement of family discussions of health issues at home, as suggested in article 4.

Sometimes, actors in a specific food industry agree on guidelines, like for instance the Danish Brewers Association agreeing not to promote soft drinks to children below their teens (Jyllands-Posten, 29.04.05). This is one actual example of demonstrating social responsibility among the companies.

**Collaboration between research and practice**

In general, marketers may benefit from an intensified collaboration between research and practice involving dissemination of research-driven knowledge to marketers and other practitioners. Also, further collaboration between food producers, retailers and advertising agencies is recommendable with the purpose of creating appropriate in-store environments; and more collaboration between food producers, packaging producers and advertising agencies is recommended with a view to creating effective food packaging solutions. Moreover, helping families and children become healthy food consumers may improve public health overall (Edwards, 2005).
Policy implications

The government may benefit from this PhD thesis by supporting public health campaigns targeted at both parents and children with a focus not only on informing but also entertaining families.

According to the Danish Consumer Council, more regulations governing promotions for unhealthy food are necessary and should be established in order to protect children (Jyllands-Posten, 29.04.05). However, it may be a theme for discussion whether more regulations are the most effective way of hindering unethical food promotions targeted at children. More regulations may prevent some marketers from promoting healthy food targeted at children and their families because of heavy challenges.

Children’s rapid development as consumers (including their increasing participation and influence in family food buying) as well as the constant emergence of new media, require politicians’ responsiveness and monitoring of this problem enabling them to launch attempts of curbing overweight, obesity and lifestyle-related diseases among children.

Moreover, public health campaigns could be even more effective if based on tighter collaboration between research, practice and policy makers. Policy-makers should support food companies and other marketers more in their attempt to act with social responsibility.

Implications for society

Society may benefit from this PhD thesis seeing improved public health when families demand, buy and consume more healthy food.
Development of in-store promotion health messages targeted both parents and children may induce families to make healthier food choices as many food decisions are made in the food stores, as found in article 1.

Development of more concise nutritional information on food labels, as suggested in article 2, could ease families’ choice of healthy food. Furthermore, improving parents’ ability to use nutritional information will enable them to teach their children about health and using labels. Children influence their family’s purchase of food, as found in article 1; and if they are taught to use nutritional information and become more involved in health, they might supply their parents with ideas for healthier food, thereby avoiding negative consequences of eating too much unhealthy food.

Food promotion material, particularly health campaigns, should be designed with the aim of arousing children’s interest in health and make them demand healthy food products furthermore supporting and inspiring children to help and ease their parents’ food buying process, as suggested in article 3. This might make children supply their parents with ideas for healthier food making health decision-making easier for parents, which could result in an avoidance of the negative consequences of eating too much unhealthy food.

Finally, our conceptual framework, as suggested in article 4, will be of value to society, as it outlines new ways of influencing families to make healthier food choices. This will improve public health by, for instance, reducing obesity and overweight, curbing eating disorders and lifestyle-related diseases indicating unnatural and unhealthy attitudes towards food. Outcomes of family social interaction may be that children become more
interested in health, that they come up with ideas for healthier food during family food buying, which will help develop a natural and healthy relationship to food among children.

The conceptual framework may also serve as guidelines for parents in the upbringing of their children. Attitudes to problems of obesity have made parents and others over-concerned about children’s consumption of energy dense snacks because these are often high in unrefined sugars and saturated fats. However, it is not the consumption itself that is critical but more the possibility that these products come to dominate a diet excluding other foods. Parents should therefore be concerned about variety of their children’s diet – a diet consisting of both healthy and unhealthy food (Stratton, 1997). Today, many parents only spend little time with their children because of work and other activities (Belch and Willis, 2001; Tufte, 1999). When they do spend time with their children, it should be more intensive. Parents should take more time to listen to their children, try to understand them, and practice ‘Children should be both seen and heard’ more completely. Parents should perceive their children as a mystery that needs to be investigated (Jyllans-Posten, 21.02.09). Parents should discuss health-related issues more with their children, and not only teach them. Also, parents should be even more open to children’s motivation for and barriers towards food choices, and they should encourage their children to be the same. This may make more families gain better insight into each other’s perspectives (John, 1999) and gain shared understandings of health as an umbrella for individual motivation and barriers in food choices, which there should be room for in order to develop and maintain individual identities. All this may solve many family conflicts regarding food and hopefully also make families choose more healthy food.
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EXECUTIVE SUMMARY

INTRODUCTION

Children have evolved into a very important consumer group being recognised as a primary market, an influencing market and a future market. At the same time, family structures have changed and family communication has become more open and democratic, making parents pay more attention to their children and their opinions. In continuation of this, the public debate shows many children as eating too much unhealthy food resulting in negative consequences for public health such as obesity and lifestyle-related diseases.

The overall purpose (management question) of this thesis is to explore family decision-making during food buying. In order to explore the issue of interest, the thesis sets up four research questions.

RESEARCH QUESTION 1

The first research question focuses on how children influence the family decision process during food buying, and whether children’s participation is a determinant of their influence. A conceptual framework was developed based on previous research on family decision-making, children’s influence and consumers’ food choices as well as on an ethnographic study of parents and children. The framework was refined after testing in a postal
questionnaire study with parents and children. The main findings are that family food decision-making is often a joint activity. Children participate and help carry out various tasks mainly consisting of practical and supportive tasks that are not labour intensive, e.g. pushing the shopping cart, while parents do the rest (e.g. most of the comparisons of food products). Children exert influence in all decision stages in the family decision process mainly in terms of initiation and choice. Children’s influence varies across decision areas with most influence on small and easy prepared meals, food products that are easy to prepare, unhealthy food (e.g. sweets) compared to healthy food products (e.g. fruit, vegetables and fish), and as regards healthy food products, fruit more than vegetables. Children’s active participation and help, among other things, determine the influence they gain. This was reported in the first article which was part of the Danish interdisciplinary research project CHILD, contract No 3414-04-00524-01, financed by the Danish Directorate for Food, Fisheries and Agri Business.

**RESEARCH QUESTION 2**

The second research question focuses on which problems families face using nutritional information on food labels during food buying, and whether families’ abilities and health consciousness are determinants of their use of nutritional information on food labels and of their preference for new nutritional labelling. Ethnographical studies with Danish families were carried out to explore children’s and parents’ use of nutritional labels and the problems they experience. Based on the findings concerning problems, three new nutritional labels were developed. In a hall-test with
parents, the three new nutritional labels were tested against the traditional one, and the relation between problems and use as well as between problems and preference for a nutritional label were investigated. The findings showed that children use nutritional information rarely, if at all. Parents seldom use this information when they seem to sense an overflow of information and a problematic presentation of especially energy distribution, and/or when their health consciousness is limited. Having to deal with information overflow, technical information and energy distribution makes parents more likely to prefer food labels with concise information. This was reported in the second article which was part of the Danish research project KITCHEN, contract No 2101-04-0026, financed by the Danish Research Agency, The Program Committee for Food and Health.

**RESEARCH QUESTION 3**

The third research question focuses on which conflicts may arise when families shop for food, and how children and parents interact and influence each other in order to solve these conflicts. Ethnographical methodologies were combined with standard market research methodologies consisting of qualitative semi-structured interviews and the studies conducted with children and their parents during food buying, dinner preparation and eating dinner. The findings showed that generally during food buying family communication is open for opinion statements and discussions between parents and their children. Many children, especially girls, have developed a clever competence realizing that when they support parents by easing food buying they get more influence, so these children use this help
influence technique with great success. This was reported in the third article. This work was part of the Danish research project KITCHEN, contract No 2101-04-0026, financed by the Danish Research Agency, The Program Committee for Food and Health.

**RESEARCH QUESTION 4**

The fourth research question focuses on *how families achieve health-related competences, and what the specific outcome competences are in a food buying perspective*. Based on a literature review, a conceptual framework is suggested outlining families’ acquisition of health-related competences to serve as a blueprint for discussing the process with relevant determinants and the relevant outcome competences in the perspective of food buying. The framework suggests that an important determinant in the process is family social interaction consisting of knowledge sharing and knowledge management following a concept-oriented family communication structure based on the individual learning properties. Parental support and guidance in order to help children help themselves (e.g. use and understand nutritional information) so that they may become independent of their parents in various consumer situations is another important aspect. The framework furthermore suggests that family health-related competences contain shared health beliefs, a mutual understanding of individual health motivations and barriers, and health agreements. This was reported in the fourth article.
GENERAL CONCLUSIONS

Decision-making during food buying is a joint family activity involving both parents and children. Children manage to achieve a high degree of influence on many decisions, among other things, because they participate actively and help out doing various tasks. These decisions may turn out to be a choice of unhealthy food.

Many decisions are made at the supermarket or other food shops, and food packaging is often used in the comparison of food products. Only rarely do families use nutritional information on food labels due to several problems in the understanding of these labels; this may result in difficulties in distinguishing among healthy and unhealthy food.

Both parents and children being active in the decision process may lead to conflicts due to gaps in preference such as between healthy and unhealthy food. Families solve these conflicts via open communication patterns and a use of various influence techniques. Children have realized that a clever and effective influence technique is to help their parents to make food buying and cooking easier and quicker.

Health-related competences seem to be an important determinant of families’ healthy food choices, thereby preventive health behaviours. It is suggested that families achieve these competences in a socialisation process where social interaction, including knowledge sharing and knowledge management based on individual learning properties, is an important determinant. It is also suggested that in a family context these competences more precisely consist of shared health beliefs, a mutual
understanding of individual health motivations and barriers, and health agreements.

LIMITATIONS AND IMPLICATIONS

The first article underscores the importance of looking at family food decision-making as a joint activity where children participate actively and gain influence. Future research may use the framework outlined in this article for structuring research on family decision-making. Extensions of this article’s framework may include an investigation of the relation between children’s consumption of specific food products and their influence on the purchase of these in order to uncover whether influence does indeed result in unhealthy eating habits. Other extensions may be an investigation of more reasons for children’s influence. This article also underscores the gains such as multi-perspective results of using mixed-method approaches, and that parents and children do not always agree on the extent of children’s influence, indicating the importance of listening to both parties in research on family dynamics and processes involved in everyday food buying. Furthermore, future research may use LISREL to investigate children’s influence in the various decision stages and areas.

Future research may extend the studies in the second article by differentiating between segments such as strategic, cued and limited information processors linking these to the outlined framework to uncover differences in the various segments’ use of nutritional information and choice of food products. Another extension could be to test the four nutritional labels among children. Furthermore, future research may
investigate the relation between problems and use of nutritional labels as well as between problems and children’s preference for nutritional labels.

Future research might extend the study in *the third article* by investigating parents’ and children’s awareness of their own use of influence techniques and that of their “adversary” in order to find out how strategic they are in their influence attempts. Also, future research could investigate age and gender differences in children’s use of influence techniques.

Future research could test the conceptual framework in *the fourth article* empirically, for instance in quantitative consumer studies using self-administrated questionnaires among parents and children. Research could also extend the framework by categorising families in segments distinguishing them in their level of shared health-related competences. Structural equation models and LISREL may be used to test an operational version of the conceptual framework with a complex structure including for instance mediators.

Marketers may also benefit from these findings in their food promotion especially in *health campaigns* by:

- *Targeting both parents and children*, since family decision-making is a joint activity that includes active participation and influence of both parents and children.

- Focusing on *small and easily prepared meals and food products* when targeting children, because their influence is extensive when it comes to these meals and products.
- Focusing on in-store market communication by integrating experience and events (e.g. child-related activities), improving shelves, coolers, freezers and store layout in general (POS), since many food choices are made in the food shops, and both parents and children participate and influence the purchase act stage in the decision process.

- In order to attract both parents and children, focusing on food packaging including more concise nutritional labels using less nutritional information, a less technical presentation form and more visual aspects like colours and symbols primarily depicting energy distribution, since the packaging is often used in the food choice in the food shops. However, only rarely do children participate in the comparison of food products and parents find, for instance, the nutritional information on food labels difficult to understand and use.

- Supporting parents and children in their attempts to influence each other to buy certain food products. For instance, support for children could be to inspire them with ways to help and ease their parents’ food buying as well as cooking process.

- Focusing on input consisting of health messages including nutrition information and fun (e.g. have an in-store monitor show how children become popular among peers because of their health interest), to the family’s internal social interactions and encouraging parents and children discuss their individual health insight.

- Using the word-of-mouth effect as a marketing communication tool to attract children, since popularity among peers is central to them.
However, market communication targeted children will always include ethical and moral aspects that marketers must consider.

Marketers’ social responsibility score may gain from helping families become healthier as it will affect their bottom line.

Lastly, society may benefit from this thesis from improved public health when families demand, buy and consume more healthy food.

At last, more interdisciplinary and collaborative research is needed in order to help families become healthier. This interdisciplinary and collaborative research should include consumer and food retail researchers, sociologists, psychologists, human nutrition researchers, and educational researchers – but also practitioners such as the food industry and marketing companies.
INTRODUKTION

Børn i dag udgør en betydningsfuld forbrugergruppe, idet de kan karakteriseres som værende et primært marked, et influerende marked såvel som et fremtidigt marked. Samtidig har familiestrukturer ændret sig, og familiekommunikation er blevet mere åben og demokratisk, hvilket har den konsekvens, at forældre giver deres børn og disse meninger mere opmærksomhed. I forlængelse heraf viser den offentlige debat, at et stigende antal børn i blandt andet Danmark spiser alt for store mængder af usunde fødevarer, hvilket i flere tilfælde resulterer i negative konsekvenser for den offentlige sundhed såsom overvægt, fedme og livsstilsrelaterede sygdomme.

Det overordnede formål (management question) med dette ph.d.-projekt er at undersøge familiers beslutningstagningen under fødevarekøb. Med henblik på at undersøge dette, opsætter ph.d.-projektet fire specifikke undersøgelsesspørgsmål (research questions):

UNDERSØGELSESPØRGSMÅL 1

Det første undersøgelsesspørgsmål fokuserer på, hvordan børn påvirker eller influerer familiens beslutningsproces under fødevarekøb, og hvorvidt børns deltagelse i diverse aktiviteter er bestemmende for deres indflydelse.
UNDERSØGELSESSPØRGSMÅL 2

Det andet undersøgelsesspørgsmål fokuserer på, hvilke problemer familier oplever ved brug af ernæringsinformation på fødevareemballager under fødevarekøb, og hvorvidt familiens forbrugerkompetencer og sundhedsbevidsthed er bestemmende for deres brug af ernæringsinformation på fødevareemballager og for deres præference for nye ernæringsmærker. Med henblik på at undersøge børns og forældres brug af ernæringsmærker og de problemer, de måtte opleve i forbindelse hermed i en familiekontekst, blev der gennemført empiriske, etnografiske studier med danske familier i naturlige omgivelser i fødevarebutikker. Baseret på resultaterne vedrørende oplevede problemer blev tre nye ernæringsmærker udviklet i samarbejde med ernæringseksperter, grafikere og marketingfolk fra en større international fødevarevirksomhed. I en hall-test med forældre blev de tre nye ernæringsmærker testet op mod det traditionelle mærke, og relationen mellem oplevede problemer og brug af ernæringsmærker samt mellem oplevede problemer og præference for ernæringsmærker blev undersøgt. Resultaterne viste, at børn yderst sjældent bruger ernæringsinformation, hvis de overhovedet bruger den. Forældre bruger sjældent denne information, når de oplever en overflod af information og en problematisk præsentation af især energifordeling, samt når deres sundhedsbevidsthed er begrænset. Netop på grund af overfloden af information, al for teknisk information og besværligt præsenteret information om især energifordeling er forældrene mere tilbøjelige til at have en præference for ernæringsmærker med kortfattet, visuelt præsenteret information. Dette blev rapporteret i den anden artikel. Denne del af projektet var en del af det danske forskningsprojekt KITCHEN, kontrakt nr. 2101-04-0026,
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UNDERSØGELSESSPØRGSMÅL 4


GENERELLE KONKLUSIONER

Familiens beslutningstagen under fødevarekøb er en fælles aktivitet, der involverer såvel forældre som børn. Børn opnår stor indflydelse på adskillige beslutninger, blandt andet fordi de deltager aktivt og hjælper
deres forældre med diverse opgaver eksempelvis i supermarkeder og andre fødevarebutikker. Disse beslutninger munder således ofte ud i et valg og køb af usunde fødevarer.

Flere beslutninger træffes i supermarkederne og andre fødevarebutikker, når familierne står foran hylder, køleskabe og fryser; og fødevareemballager anvendes ofte på forskellig vis til sammenligning af fødevarealternativer. Familier bruger dog kun sjældent ernæringsinformation på fødevareemballager, fordi de ofte oplever problemer i forståelsen af disse mærker; dette resulterer i besværigheder med hensyn til at skelne mellem de sunde og usunde fødevarer og dermed med at træffe sunde fødevarevalg.

Siden både forældre og børn er aktive deltagere i beslutningsprocessen under fødevarekøb, opstår der af og til konflikter som et resultat af præferenceforskelle, eksempelvis mellem sunde og usunde fødevarer. Familier løser konflikterne ved åbne kommunikationsmønstre og brug af adskillige indflydelsesteknikker. Børnene har indset, at en smart og effektiv indflydelsesteknik er at hjælpe deres forældre med a fødevarekøb og -tilberedning.

**BEGRÆNSNINGER OG IMPLIKATIONER**

Den anden artikel understreger betydningen af at gøre ernæringsinformation på fødevareemballager mere lettilgængelig og letforståelig for børn og deres familier som led i forsøget på at få dem til at træffe sundere fødevarevalg. Dette delprojekt skelner ikke mellem forbrugersegmenter med forskellige informationsbearbejdningselever eller forskellige niveauer af oplevede problemer. Fremtidig forskning kunne udvide dette delprojekt ved at skelne mellem segmenter som eksempelvis strategiske, stikords- og begrænsede informationsbearbejdere blandt børn og forældre og linke disse til den konceptuelle ramme for at afdække forskelle mellem segmenterne i brugen af ernæringsinformation og valg af specifikke fødevarer. En anden begrænsning ved dette delprojekt er, at det ikke inkluderer en test blandt børn af de fire ernæringsmærker. Fremtidig forskning kunne derfor udvide dette delprojekt ved at teste disse mærker blandt børn for så at sammenligne resultatet med forældre-resultaterne. En tredje begrænsning ved dette delprojekt er, at det ikke inkluderer anden Point-of-Purchase stimuli end fødevareemballager og ernæringsmærkning. Den kvalitative del var åben for diverse påvirkninger i butiksmiljøerne, og familierne lod ikke til at blive påvirket af sundhedsbudskaber andre steder i dette miljø; men en test eksempelvis i form af eksperimenter med andre former for POP-stimuli med sundhedsbudskaber kunne være interessant som supplement til ernæringsmærker på fødevareemballagerne. Endvidere er det en begrænsning ved dette delprojekt, at det inkluderer et begrænset antal items på grund af designet i form af en hall-test, der helst ikke skulle vare for lang tid; flere items og flere faktorer ville eventuelt kunne være med til at styrke de statistiske analyser, der på nuværende tidspunkt fremstår som forholdsvis svage.
Den tredje artikel understreger betydningen af at undersøge børns og forældres brug af indflydelsesteknikker i deres forsøg på at løse sundheds-nydelses konflikter. En begrænsning ved dette delprojekt er, at det ikke undersøger, i hvor høj grad forældre og børn er opmærksomme på eller bevidste om deres egen og hinandens brug af indflydelsesteknikker. Fremtidig forskning kunne derfor udvide delprojektet ved at undersøge dette med henblik på at finde ud af, hvor strategiske forældre og børn hver især er i deres indflydelsesforsøg. Yderligere er dette delprojekt begrænset ved, at det ikke nærmere undersøger alders- og kønsforskelle i forbindelse med brug af indflydelsesteknikker under fødevarekøb. En udvidelse kunne derfor være at undersøge dette.

Virksomheder og andre praktikere kan også drage nytte af dette ph.d.-projekt i deres udvikling og markedsføring af fødevarer, især i forbindelse med sundhedskampagner, ved at

- målrette markedskommunikationen til både forældre og børn, idet familiens beslutningstagen er en fælles aktivitet med både forældre og børn som aktive deltagere og influenter

- fokusere på små og let-tilberedte måltider og fødevareprodukter i forbindelse med målretning til børn, da børn opnår størst indflydelse på disse måltider og fødevareprodukter

- fokusere på in-store markedskommunikation ved at integrere oplevelser og begivenheder (eksempelvis børnerelaterede aktiviteter), forbedre design af hylder, køleskabe, frysere og butikken generelt set (POS), i og med at mange fødevarevalg foretages i fødevarebutikkerne, og at både forældre og børn også deltager i og influerer på det praktiske købshandlingsstadium i beslutningsprocessen

- fokusere på fødevareemballage inklusiv mere koncise ernæringsmærker med en mindre mængde ernæringsinformation, en mindre teknisk præsentationsform og flere visuelle aspekter som farver og symboler, der især afbilder energifordeling med henblik på at tiltrække såvel forældre som børn. Fødevareemballage anvendes ofte i fødevarevalget i fødevarebutikkerne, men børn deltager ikke særligt ofte i sammenligningen af fødevareprodukter ud fra ernæringsinformation, og forældre oplever ernæringsinformationen på fødevareemballager som værende besværlig at forstå og bruge
- støtte forældre og børn i deres forsøg på at påvirke hinanden til at købe bestemte fødevareprodukter. Eksempelvis kunne støtte til børn være inspiration til, hvordan børn hjælper deres forældre ved at lette købs- og tilberedningshandlingen

- fokusere på at *udbyde mere integreret eller holistisk input bestående af sundhedsbudskaber, inklusiv ernæringsinformation og underholdning* (eksempelvis ved på in-store tv at vise børn, der bliver populære blandt kammerater på grund af deres sundhedsinteresse) til *fami liernes interne sociale interaktioner* og opfordre forældre og børn til at diskutere deres individuelle sundhedsindsigt (’word-of-mouth’ mellem forældre og børn)

- bruge ’word-of-mouth’-effekter mellem børn og deres kammerater som markedskommunikationsteknik for at tiltrække børn, da popularitet blandt kammerater er meget centralt for børn

Markedsføring målrettet børn vil altid inkludere etiske og moralske aspekter, som enhver virksomhed på området bør overveje nøje.

Virksomheder kan opnå fordele ved at hjælpe familier til at blive sundere forbrugere ved at styrke den sociale ansvarlighed som blandt andet tydeliggøres på bundlinjen.

*Samfundet* kan ligeledes drage nytte af dette ph.d.-projekt, da resultatene burde kunne hjælpe til at øge den offentlige sundhed ved at få børnefamilier til at efterspørge, købe og forbruge flere sunde fødevareprodukter. Til sidst kan det siges, at mere tværfaglig forskning og samarbejde med praksis er nødvendig for at få børnefamilier til at blive sundere forbrugere.