



## EVALUATION OF THE HEALTHY LIFESTYLE BEHAVIORS OF PHYSICAL EDUCATION TEACHERS

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### **Abstract:**

In this study, it was aimed to evaluate the healthy lifestyle behaviors of physical education teachers, working in Istanbul Bahçelievler, district according to some variables. The sample of the research carried out as descriptive research; It constitutes a total of 98 physical education teachers in 65 middle schools and high schools in Bahçelievler district of Istanbul. In the study, a structured questionnaire consisting of two parts was used as data collection method. In the first part of the questionnaire; questions about the demographics of the participants, in the second part, in order to evaluate the healthy lifestyle behaviors of the physical education teachers Walker and ark(1996) developed by Bahar and ark (2008) used the Turkish version of healthy living behavior scale. The obtained data were recorded in the SPSS package program. Statistical analysis Mann-Whitney U and Kruskal Wallis H difference analysis were applied. As a result, although significant differences were found in some of the subscales of healthy lifestyle behavior according to gender, age, marital status and professional experience variables, no significant difference was found in some subscales.

**Keywords:** health, healthy life style behaviors, physical education teachers

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## 1. Introduction

Today, the concept of health is defined in different ways depending on the reasons such as the worker and field of expertise of the person who defines it. Among them, the most widely accepted and widely accepted definition of health is the definition of health done by the World Health Organization (WHO) in 1946. According to this definition, health; *"Not only that there is no illness or disability, but also that there is full peace and goodness in physical, spiritual and social aspects"*. The modern and contemporary aspect of this definition is that it does not constrain the disease to the extent of symptoms and treats the person as a whole psychologically and socially (Baltas, 2008). Healthy life behaviors are conscious behaviors that individuals try to implement to protect and improve the health of themselves and others. Demographic factors are one of the most important factors in shaping individuals' healthy lifestyle behaviors. Attitudes and behaviors towards the healthy lifestyle of individuals have an important place in the prevention or treatment of many diseases. Because it is necessary to increase the levels of positive health and lifestyle of individuals and society so that diseases, deaths and injuries can be minimized. Health promotion also includes health education and health behaviors (Özvarış, 2006). The first steps in developing healthy lifestyle behaviors are taken in society and in the family, then developed and changed with education (Yalçınkaya et al., 2007). Because education is an ongoing phenomenon, the basic health education and acquired health behaviors taken by schools constitute health habits that will affect children for a lifetime. One of the most important stakeholders that schools can contribute to improve health is physical education teachers. The knowledge and attitudes of the physical education teachers, who are often very popular and sampled students, to their health-related students will have a significant share in the growth of healthy generations. Therefore, in the formation of a healthy society, physical education teachers are an important group with the reason that they are both role models and power to influence other individuals. For this reason, physical education teachers should demonstrate motivation-enhancing behaviors in order to develop positive health behaviors for the individuals around them who are not aware of the importance of developing health. Preservation and development of health is one of the most important issues in people's life, perhaps the most important. Many studies have been carried out on the way of healthy life to date and the effect of demographic factors on health behaviors has been investigated. The goal of these surveys is to increase the control of individuals on their health and to prevent diseases that occur with their lifestyle. Therefore, in this study, it was aimed to evaluate the healthy lifestyle behaviors of the physical education teachers working in the province of Bahçelievler in Istanbul according to some variables.

## 2. Material and Methods

This work is produced from the master's thesis no. 466781. A total of 98 physical education teachers in 65 middle schools and high schools in the province of Bahçelievler in Istanbul province volunteered to participate in the research. Simple random sampling method, one of the random sampling methods, has been used in the selection of the sample. A structured questionnaire consisting of two parts was used as data collection method in the study. In the first part of the questionnaire, demographics of participants were included. Healthy Life Style Behavior Scale, Walker and ark (1996) developed by Bahar and Ark (2008) used the Turkish version of healthy living behavior scale. Scale is a likert type scale scored between 1-4. Scale of the scale was never used (1), sometimes (2), often (3) regularly (4). For the entire scale, the lowest score is 52 and the highest score is 208. In addition, the scale consists of 52 items and sub-factors These; spiritual development, health responsibility, physical activity and exercise, nutrition, interpersonal relationships and stress management. Factors and question numbers in the questionnaire and the meanings they express are as follows. Spiritual development (6,12,18,24,30,36,42,48,52), health responsibility (3,9,15,21,27,33,39,45,51), physical activity and exercise (4,10,16,22,28,34,40,46), nutrition (2,8,14,20,26,32,38,44,50), interpersonal relationships (1,7,13,19,25,31,37,43,49) and stress management (5,11,17,23,29,35,41,47). Analysis of collected data was done using SPSS 24.0 package program Descriptive and descriptive statistical methods have been applied for these analyzes. Tests used; frequency analysis to find demographics, Shapiro-Wilk and Kolmogorov-Smirnov normality tests for the determination of normality status, Mann-Whitney U and Kruskal Wallis-H tests for difference analysis. The use of Mann-Whitney U and Kruskal Wallis-H tests revealed that the causal data were not normally distributed (nonparametric). Mann-Whitney U and Kruskal Wallis-H tests are statistical tests to test differences between subgroups of non-normally distributed data.

## 3. Results and Discussion

Healthy lifestyle behaviors revealed a significant difference in health responsibilities, exercise and physical activity and nutrition subscales in favor of women when analyzing subscale differences according to sex. When national and international literature are examined, it is seen that there are studies examining the healthy life behaviors of physical education and other branch teachers Pekel and Ark 2015; Güler and ark 2008; Kaya and ark 1998; Karakoç, 2006; Kardaş, 1995) When the literature is examined, findings supporting the results of the study are found. In Özçelik's (2012) study of healthy lifestyle behaviors of pre-community professionals, it was found that

women's scores on health responsibility and nutrition subscales were significantly higher than those of men. On the other hand, in another study examining the healthy lifestyle behaviors of academic staff working at the university, the Tiryaki (2013) research group found a significant difference in favor of men in the physical activity sub-dimension in terms of gender change. In the analysis of differences according to marital status, there was a significant difference in health responsibility, exercise and physical activity and nutrition sub-dimensions in favor of men. However, in another study which examines the level of healthy living behavior of Physical Education Teachers, it is seen that Kafkas et al (2012) did not differ significantly in terms of the average scores of marital status variable. Özçelik (2012) did not find a statistically significant difference in the healthy lifestyle behaviors of the marital status sub-factor in the study conducted to the pre-community occupational groups. When the analysis of the subscale differences in terms of age change was examined, 41+, 26-30 and 36-40 age groups in the spiritual development subscale were found to have higher scores than 20-25 and 31-35 age groups and found significant differences. In the sub-dimension of health responsibility, 41+, 26-30 and 36-40 age groups were found to have higher scores than 20-25 and 31-35 age group and significant differences were found. In the exercise and physical activity subscale, 41+, 26-30 and 36-40 age groups were found .to have higher scores than 20-25 and 31-35 age groups, and significant differences were found. In the nutrition subscale, 26-30 and 36-40 age groups were found to have higher scores than 20-25, 31-35 and 41+ age groups and found significant differences. In the stress management subscale, 41+, 26-30 and 36-40 age groups were found to have higher scores than 20-25 and 31-35 age groups, and significant differences were found. When we look at the literature, in a study examining the health behaviors of the administrative staff working at İmer (2013) university, there was no significant difference in the subscales of healthy life style behaviors of the personnel in terms of age variables.

When the subscales of the scale of healthy lifestyle behaviors were examined in terms of working year change in the profession, a significant difference was found in the stress management subgroups. It has been found that 16-20 and 11-15 years of study have higher scores than 1-5, 6-10 and 21+.In the study conducted by Kafkas et al. (2012), it is seen that physical education teachers differ significantly in terms of total seniority, spiritual development, health responsibility, exercise, nutrition, interpersonal support and stress management subscales in terms of total scores.

#### 4. Conclusion

As a result, healthy lifestyle behaviors of physical education teachers do not differ according to sex. In other words, the healthy lifestyle behaviors of men and women are similar. However, women are more likely to behave more positively than men. According to the marital status, there was a difference between participants' answers. Healthy lifestyle behaviors of married participants are more likely to be statistically different than single participants. According to this, it can be said that being single has negative effects on behaviors towards healthy life. The age of physical education teachers is to differentiate healthy lifestyle behaviors. In general, it is possible to say that teachers between the ages of 20-25 do not show positive behaviors, it is the most favorable period between the ages of 26-30, and teachers' approaches follow a fluctuating course in the following years. A significant relationship was found only between the years of vocational training and the healthy lifestyle behaviors of physical education teachers, only in the stress management sub-dimension

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## B. Elements

### a. Figures and Tables

**Table 1: Demographic Characteristics of Participants**

Demographic Feature	Variable	N	%
Gender	Male	62	63,3
	Female	36	36,7
	Total	98	100,0
Marital status	Married	56	57,1
	Single	42	42,9
	Total	98	100,0
Age	20 – 25	24	24,5
	26 – 30	22	22,4
	31 – 35	16	16,3
	36 – 40	26	26,5
	41+	10	10,2
	Total	98	100,0
Occupational Working Year	1 – 5	46	46,9
	6 – 10	18	18,4
	11 – 15	24	24,5
	16 – 20	8	8,2
	21+	2	2,0
	Total	98	100,0

63.3% of the study group were males and 36.7% were females the individuals in the group, 57.1 were married and 42.9 were single. Most of the physical education teachers who participated in the research (89.8%) were in the age range of 20-40 years and they were quite young. 46.9% of the participating physical education teachers participated in the study for 1-5 years, 18.4% for 6-10 years, 24.5% for 11-15 years, 8.2% for 16- 20 years and 2,0% are 21 and over years in working life.

**Table 2:** Results of Differential Analysis of  
Healthy Life Style Behavior Scale Sub-Dimensions According to Sex Variables

	Grup	N	Order Avg.	Rank Top.	U	Z	p
Spiritual Development	Male	62	48,82	3027	1074	-,310	,756
	Female	36	50,67	1824			
Health Responsibility	Male	62	43,73	2711	758	-2,646	,008
	Female	36	59,44	2140			
Exercise and Physical Activity	Male	62	44,89	2783	830	-2,112	,035
	Female	36	57,44	2068			
Nutrition	Male	62	44,63	2767	814	-2,231	,026
	Female	36	57,89	2084			
Interpersonal Support	Male	62	47,89	2969	1016	-,739	,460
	Female	36	52,28	1882			
Stress Management	Male	62	48,11	2983	1030	-,637	,524
	Female	36	51,89	1868			

The research group compares the scores obtained from the subscales of the Healthy Lifestyle Behaviors Scale in terms of gender change. There was a significant difference in favor of women in the sub-dimension of health responsibility ( $p = 0,008$ ), exercise and physical activity sub-dimension ( $p = 0,035$ ) and nutrition sub-dimension ( $p = 0,026$ ). In the other subscales of the scale, there were no differences in terms of gender variation ( $p > 0.05$ ).

**Table 3:** Results of Differential Analysis of  
Healthy Life Style Behavioral Scale Sub-Dimensions by Marital Status

	Group	N	Order Avg.	Rank Top.	U	Z	p
Spiritual Development	Married	56	53,14	2976	972	-1,467	,142
	Single	42	44,64	1875			
Health Responsibility	Married	56	56,04	3138	810	-2,635	,008
	Single	42	40,79	1713			
Exercise and Physical	Married	56	56,71	3176	772	-2,906	,004
	Single	42	39,88	1675			
Nutrition	Married	56	54,68	3062	886	-2,087	,037
	Single	42	42,60	1789			
Interpersonal Support	Married	56	50,57	2832	1116	-,432	,666
	Single	42	48,07	2019			
Stress Management	Married	56	53,68	3006	942	-1,687	,092
	Single	42	43,93	1845			

In the analysis of differences according to marital status, significant differences were found in the health responsibility subscale ( $p = 0,008$ ), exercise and physical activity subscale ( $p = ,004$ ) and nutrition subscale ( $p = ,037$ ). Analysis of differences made



according to marital status. In the other subscales of the scale, there was no difference in terms of marital status ( $p > 0.05$ ). Table 40 compares the scores obtained from the subscales of healthy lifestyle behaviors in terms of marital status change in the research group. In the sub-dimension of health responsibility ( $p = 0,008$ ), exercise and physical activity subscale ( $p = (p =, 037)$ ) were found to have significant differences in favor of marriage.

**Table 4:** Results of Difference Analysis According to Age of Health Dimensions of Healthy Life Style Behaviors Scale

	Yaş	N	Order Avg.	Kay-kare	SD	P
<b>Spiritual Development</b>	20-25	24	38,42	10,653	4	,031
	26-30	22	56,95			
	31-35	16	38,75			
	36-40	26	54,96			
	41+	10	62,70			
<b>Health Responsibility</b>	20-25	24	30,25	17,048	4	,002
	26-30	22	59,68			
	31-35	16	46,50			
	36-40	26	56,35			
	41+	10	60,30			
<b>Exercise and Physical</b>	20-25	24	32,83	13,232	4	,010
	26-30	22	56,95			
	31-35	16	45,75			
	36-40	26	56,65			
	41+	10	60,50			
<b>Nutrition</b>	20-25	24	33,67	12,626	4	,013
	26-30	22	62,32			
	31-35	16	49,50			
	36-40	26	53,88			
	41+	10	47,90			
<b>Interpersonal Support</b>	20-25	24	37,50	8,888	4	,064
	26-30	22	61,05			
	31-35	16	48,25			
	36-40	26	53,65			
	41+	10	44,10			
<b>Stress Management</b>	20-25	24	33,92	13,130	4	

	26-30	22	56,32			,011
	31-35	16	43,00			
	36-40	26	58,88			
	41+	10	57,90			

The research group compares the scores obtained from the subscales of the Healthy Life Style Behaviors Scale in terms of age change. Accordingly, there was a significant difference in the spiritual development sub-dimension ( $p = ,031$ ). 41+, 26-30 and 36-40 age group were found to have higher scores than 20-25 and 31-35 age group. Significant differences were found in the sub-dimension of health responsibility ( $p = ,002$ ). 41+, 26-30 and 36-40 age group were found to have higher scores than 20-25 and 31-35 age group. There was a significant difference in exercise and physical activity sub-dimension ( $p = ,010$ ). 41+, 26-30 and 36-40 age group were found to have higher scores than 20-25 and 31-35 age group. There was also a significant difference in nutrition sub-dimension ( $p = ,013$ ). 26-30 and 36-40 age groups have higher scores than 20-25, 31-35 and 41+ age groups. There was a significant difference in the stress management sub-dimension ( $p = ,011$ ). 41+, 26-30 and 36-40 age group were found to have higher scores than 20-25 and 31-35 age group. In addition to these, no significant difference was found in the interpersonal support sub-dimension ( $p > 0,05$ ).

**Table 5:** Results of Differential Analysis of Healthy Life Style Behavior Scale Sub-Dimensions According to Occupational Year

	Age	N	Order Avg.	Kay-kare	SD	P
<b>Spiritual Development</b>	1-5	46	45,59	8,681	4	,070
	6-10	18	49,50			
	11-15	24	53,75			
	16-20	8	68,75			
	21+	2	11,50			
<b>Health Responsibility</b>	1-5	46	44,50	4,994	4	,288
	6-10	18	50,72			
	11-15	24	57,17			
	16-20	8	57,75			
	21+	2	28,50			
<b>Exercise and Physical</b>	1-5	46	42,80	8,638	4	,071
	6-10	18	48,50			
	11-15	24	63,25			
	16-20	8	52,00			
	21+	2	37,50			
<b>Nutrition</b>	1-5	46	46,80	7,019	4	,135

	6-10	18	53,06			
	11-15	24	58,00			
	16-20	8	40,75			
	21+	2	12,50			
<b>Interpersonal Support</b>	1-5	46	47,41	5,306	4	,257
	6-10	18	51,94			
	11-15	24	54,33			
	16-20	8	51,75			
	21+	2	8,50			
<b>Stress Management</b>	1-5	46	47,89	10,074	4	,039
	6-10	18	41,50			
	11-15	24	57,50			
	16-20	8	63,50			
	21+	2	6,50			

The Kruskal-Wallis test was used to compare the scores of the research group in terms of the profession working year variance from the subscales of the healthy lifestyle behaviors scale. Accordingly, a significant difference was found in the stress management subgroups. ( $P = 039$ ). It has been found that 16-20 and 11-15 years of study have higher scores than 1-5, 6-10 and 21+. No significant differences were found in other sub-dimensions.

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