Original article

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Parental attitudes toward children's rights in a pediatric outpatient clinic: Care and protection versus self-determination. A cross-sectional study

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Abstract

Introduction. Parental attitudes toward children's rights may shape how children participate in health care according to their age and developmental level. Evidence from pediatric outpatient settings in Türkiye is limited.

Objective. To examine the relationships among the subdimensions of parental attitudes toward children's rights and identify those sharing variance with Self-Determination attitudes.

Population and methods. Cross-sectional, descriptive-correlational study conducted in the pediatric outpatient clinic of a tertiary hospital, April–June 2026. Of 860 invited parents, 513 completed the questionnaire (59.7%). The Parental Attitudes Toward Children's Rights Scale was used (subdimensions: State Assurance and Support, Care and Protection, Self-Determination; Cronbach's alpha 0.811–0.867). Two-stage hierarchical regression was applied, with sociodemographic variables in Block 1 and the two remaining attitudinal subdimensions in Block 2. Because the variables entered in Block 2 and the outcome derive from the same instrument, the findings were interpreted as shared attitudinal variance rather than as independent prediction.

Results. Care and Protection had the highest mean (4.45 ± 0.34), followed by State Assurance and Support (4.39 ± 0.36); Self-Determination was the lowest (3.97 ± 0.37). Block 1 contributed negligibly ($R^2 = 0.011$; $p = 0.322$). Block 2 substantially increased explained shared variance ($R^2 = 0.523$; $\Delta R^2 = 0.512$; $p < 0.001$), with State Assurance and Support ($\beta = 0.432$) and Care and Protection ($\beta = 0.332$) both significant ($p < 0.001$).

Conclusions. Parents strongly endorsed protective and institutional-assurance rights, while self-determination scored lowest. These findings support addressing protective orientations together with the child's right to participate in pediatric care.

Keywords: *children; human rights; parents; attitude; personal autonomy.*

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INTRODUCTION

Rogers and Wrightsman conceptualized attitudes toward children's rights along two dimensions: nurturance-protection, understood as protecting the child and exercising adult authority to decide on the child's behalf, and self-determination, understood as the child's right to participate in decisions affecting their own life and to express their views.[1] Adults consistently endorse nurturance-protection more strongly than self-determination,[2-4] and studies in parent samples reproduce this pattern, with support varying according to sociodemographic characteristics.[5]

This gap may be accentuated in the Turkish context. Kagitcibasi's Family Change Model proposes that, in societies with strong family ties, the parent–child relationship is organized around psychological closeness and connectedness, and child autonomy may at times be perceived as a threat to family unity.[6] Studies directly examining parental attitudes toward children's rights in Türkiye remain scarce, and several have been conducted with non-parent samples such as university students.[7] International assessments of Türkiye's implementation of the UN Convention on the Rights of the Child have repeatedly identified respect for the views of the child as an area of least progress,[8] while General Comment No. 12 frames the child's right to be heard as an obligation to be implemented in practice, not merely a principle.[9]

Age and developmentally appropriate participation of children is therefore relevant not only ethically but also clinically, particularly for confidentiality in adolescent medicine and for the gradual transfer of treatment responsibility in chronic illness. The objective was to examine the relationship between parental Care and Protection, State Assurance and Support and Self-Determination attitudes among parents attending a pediatric outpatient clinic, together with the role of sociodemographic variables. Three hypotheses were formulated: (H1) Care and Protection and State Assurance and Support would be positively associated with Self-Determination; (H2) sociodemographic variables would show a limited explanatory contribution to Self-Determination; and (H3) Self-Determination would show the lowest mean score among the three subdimensions.

Population and methods

Design and participants

Cross-sectional, descriptive-correlational study carried out in the pediatric outpatient clinic of a tertiary care hospital between 18 April and 16 June 2026, using consecutive, non-probability sampling. Inclusion criteria were age ≥18 years, having at least one child aged 1 to 18 years, ability to read and understand Turkish, and willingness to participate.

Parents attending the pediatric outpatient clinic were approached consecutively by a member of the research team during clinic hours and invited to complete the electronic questionnaire while waiting for the consultation, primarily using their own smartphones. Probability sampling was not feasible because the clinic has a continuous and rapidly changing patient flow and no sampling frame of attending parents exists from which a probability sample could have been drawn; the findings should therefore be interpreted as reflecting the parents who attended this clinic and agreed to participate during the study period, rather than parents in Türkiye more broadly.

Of 860 eligible parents invited, 513 agreed and completed the questionnaire (participation rate 59.7%); the remaining 347 (40.3%) declined when the questionnaire was offered. Because data collection began only after written informed consent, no sociodemographic information was recorded for parents who declined, so participants and non-participants could not be compared. There was no item-level missing data, since the questionnaire did not allow advancing without answering each item.

With G*Power 3.1, a medium effect size ($f^2 = 0.15$), $\alpha = 0.05$ and power $(1 - \beta) = 0.80$, a multiple linear regression with seven explanatory variables required approximately 103 participants.

Instruments

A Personal Information Form developed by the researchers recorded maternal and paternal age, education and occupation, number of children, family type and income level.

The Parental Attitudes Toward Children's Rights Scale was developed by Yurtsever as a doctoral dissertation[10] and was subsequently published in a peer-reviewed, open-access journal,[11] where its development and psychometric properties are reported in full; the dissertation is also freely available through the National Thesis Center of the Turkish Council of Higher Education (Thesis No. 231784). It comprises 63 items rated

on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree) and operationalizes the two attitudinal poles described by Rogers and Wrightsman (1): State Assurance and Support (23 items) and Care and Protection (15 items) represent the nurturance pole, whereas Self-Determination (25 items) forms a single subdimension. Subdimension scores were calculated as item means, so that all scores lie on the 1–5 metric, with higher scores indicating more positive attitudes. The standardization sample, the factor structure of the original development study and further detail are summarized in the *Supplementary material*. Written permission to use the scale was obtained from the developer.

Statistical analysis

Analyses were performed with SPSS 26.0, with assumption checks in Python (SciPy, statsmodels). Sociodemographic variables are reported as frequencies and percentages and scale scores as mean (M) and standard deviation (SD); parametric methods were used. Internal consistency was assessed with Cronbach's alpha and the relationships among subdimensions with Pearson correlation coefficients.

The variables included in the model were specified a priori and follow the structure of the instrument. Rogers and Wrightsman distinguish two attitudinal poles,[1] and in this scale the nurturance pole is represented by two subdimensions whereas self-determination forms a single one.[10,11] Self-Determination was therefore designated as the dependent variable and the two nurturance subdimensions as the attitudinal variables entered in Block 2 before the analyses were run; no alternative combination was tested, and the model was not selected on the basis of the results.

A two-stage hierarchical multiple regression was performed with the Self-Determination score as the dependent variable. Block 1 comprised maternal education, paternal education, income level and number of children (entered as ordinal variables) and family type (dummy-coded: 0 = nuclear, 1 = extended); Block 2 added Care and Protection and State Assurance and Support. Because treating ordinal variables as continuous assumes equal spacing, Block 1 was re-estimated with all ordinal variables dummy-coded as a sensitivity check.

Because the variables entered in Block 2 are subdimensions of the same instrument as the dependent variable, the model was interpreted as shared variance among co-developed dimensions rather than as independent prediction, and the terms association and shared variance are used in place of prediction throughout. Supplementary analyses of discriminant validity and of the robustness of the Block 1 findings are reported in the *Supplementary material*.

Regression assumptions—normality of standardized residuals, heteroscedasticity, multicollinearity (tolerance and variance inflation factor [VIF]) and influential observations (Cook's distance)—were evaluated.

As an exploratory analysis, Care and Protection and Self-Determination scores were compared by maternal education. The literate-only group (n = 6) was reported descriptively only; the primary-school, high-school and university groups were compared with Welch's ANOVA and Games–Howell post-hoc tests, with η^2 as effect size. Significance was $p < .05$, and $p < .025$ (Bonferroni) for the two exploratory comparisons.

Ethical considerations

The study was approved by the Başakşehir Çam and Sakura City Hospital Non-Interventional Clinical Research Ethics Committee (KAEK/178, 15 April 2026) and conducted in accordance with the Declaration of Helsinki. Participation was voluntary and written informed consent was obtained from all participants.

RESULTS

Approximately half of the 513 participating parents were university graduates and had two children *(Table 1)*.

Internal consistency was good to excellent, and the highest mean was for Care and Protection, followed by State Assurance and Support, with Self-Determination lowest (*Table 2*).

All subdimensions were strongly, positively and significantly correlated, most strongly between State Assurance and Support and Care and Protection ($r = 0.822$; all $p < 0.001$) (*Table 2*).

Supplementary analyses showed no single dominant factor underlying the items (first unrotated component = 20.5% of item variance), but after correction for attenuation State Assurance and Support and Care and Protection were barely distinguishable (disattenuated $r = 0.98$), whereas Self-Determination remained more clearly separable from both ($r = 0.83$ with each).

In the hierarchical regression, Block 1 contributed negligibly to Self-Determination

Table 1. Sociodemographic characteristics of participants (N = 513)

Variable	n	%
Maternal education		
Literate only	6	1.2
Primary school	69	13.5
High school	202	39.4
University	236	46.0
Paternal education		
Literate only	6	1.2
Primary school	53	10.4
High school	202	39.4
University	252	49.1
Number of children		
1	165	32.2
2	259	50.5
≥ 3	89	17.4
Family type		
Nuclear	437	85.2
Extended	76	14.8
Income level		
Income lower than expenses	130	25.3
Income equal to expenses	283	55.2
Income higher than expenses	100	19.5

Table 2. Descriptive statistics, internal consistency and correlations among subdimensions (N = 513)

Subdimension	Items	M	SD	α	1	2	3
1. State Assurance and Support	23	4.39	0.36	0.867	—		
2. Care and Protection	15	4.45	0.34	0.811	0.822***	—	
3. Self-Determination	25	3.97	0.37	0.820	0.697***	0.679***	—
Total scale	63	4.24	0.32	0.929			

*M: mean; SD: standard deviation; α: Cronbach's alpha. ***p < .001. Disattenuated correlations and Harman's single-factor test are reported in the* Supplementary material.

(R^2 = 0.011; F(5,507) = 1.17; p = 0.322), with no sociodemographic variable independently associated with the outcome. The same conclusion held when all ordinal variables were dummy-coded (R^2 = 0.038; F = 1.80; p = 0.051; the *Supplementary material*).

Adding Care and Protection and State Assurance and Support in Block 2 substantially increased the explained shared variance (ΔR^2 = 0.512; $\Delta F(2,505)$ = 271.23; p <0.001). The final model accounted for 52.3% of the variance (F(7,505) = 79.22; p <0.001). State Assurance and Support and Care and Protection were both positively and significantly associated with Self-Determination (β = 0.432 and 0.332 respectively; both p <0.001), whereas no sociodemographic variable retained an independent association *(Table 3).*

Model assumptions were met (Shapiro–Wilk p = 0.126; Breusch–Pagan p = 0.561; VIF 1.049–3.193; maximum Cook's distance 0.049).

Maternal education produced a statistically significant difference in Care and Protection attitudes, with primary-school graduates scoring lower than both high-school and university graduates, who did not differ from each other; no significant difference was found for Self-Determination after Bonferroni correction *(Table 4).*

DISCUSSION

The three subdimensions were not endorsed equally, supporting H3: support was strong for rights related to care, protection and institutional assurance, and more cautious toward the child expressing views and taking part in decisions. This is consistent with evidence that adults endorse nurturance-protection more strongly than

Table 3. Hierarchical regression analysis for dimensions sharing variance with Self-Determination attitudes

Variable	B	SE B	95% CI for B	β	t	p
Block 1: Sociodemographic variables						
Maternal education	0.013	0.031	−0.049 to 0.075	0.027	0.415	0.678
Paternal education	0.043	0.032	−0.020 to 0.105	0.084	1.333	0.183
Income level	−0.007	0.026	−0.058 to 0.044	−0.013	−0.286	0.775
Number of children	−0.014	0.024	−0.061 to 0.034	−0.025	−0.569	0.570
Family type	0.035	0.048	−0.060 to 0.131	0.033	0.729	0.466
Block 2: Full model						
Maternal education	−0.029	0.022	−0.072 to 0.014	−0.059	−1.333	0.183
Paternal education	0.003	0.022	−0.041 to 0.047	0.007	0.153	0.879
Income level	0.001	0.018	−0.034 to 0.037	0.002	0.064	0.949
Number of children	−0.010	0.017	−0.043 to 0.023	−0.019	−0.595	0.552
Family type	−0.026	0.034	−0.092 to 0.041	−0.025	−0.752	0.452
Care and Protection	0.362	0.060	0.245 to 0.480	0.332	6.047	<0.001
State Assurance and Support	0.441	0.056	0.332 to 0.550	0.432	7.942	<0.001

B: unstandardized coefficient; SE B: standard error; CI: confidence interval; β: standardized coefficient. Maternal education, paternal education, income level and number of children entered as ordinal variables; family type as a dummy variable (0 = nuclear, 1 = extended). Block 1: R^2 = 0.011; adjusted R^2 = 0.002; F(5,507) = 1.17; p = 0.322. Block 2: R^2 = 0.523; adjusted R^2 = 0.517; F(7,505) = 79.22; p < 0.001. Block 2 change: ΔR^2 = 0.512; $\Delta F(2,505)$ = 271.23; p < 0.001. Sensitivity check with dummy-coded ordinal variables: Block 1 R^2 = 0.038; F = 1.80; p = 0.051.

Table 4. Subdimension scores by maternal education level

Maternal education	n	Care and Protection M (SD)	Self-Determination M (SD)
Literate only	6	4.27 (0.51)	3.87 (0.56)
Primary school	69	4.29 (0.43)	3.87 (0.40)
High school	202	4.45 (0.30)	4.00 (0.34)
University	236	4.50 (0.32)	3.98 (0.37)
Welch's F		F(2,174) = 6.84	F(2,185) = 2.92
p		0.001	0.057
η^2		0.040	0.013

Inferential tests (Welch's ANOVA with Games–Howell post-hoc) were conducted across the primary-school, high-school and university groups; the literate-only group (n = 6) is shown descriptively only. For Care and Protection: primary < high school (p = 0.013) and primary < university (p = 0.001); high school vs. university, not significant (p = 0.306). Because the Self-Determination omnibus test was non-significant, post-hoc comparisons were not interpreted.

self-determination and participation rights,[2-4] and with parent samples in which protection under adult guidance is more readily accepted.[5,12] In the Turkish context, this is compatible with societies with strong family ties tending toward parental authority and toward defining the child's best interest through adult guidance.[6]

Lower support for self-determination is directly relevant to child-centered care, informed consent and developmentally appropriate assent.[9,13] In chronic conditions requiring long-term self-care—such as type 1 diabetes, asthma or epilepsy—restricting developmentally appropriate autonomy may adversely affect adherence and the assumption of responsibility for disease management.[14] These considerations derive from the wider literature rather than from the present data, which assessed neither clinical outcomes nor children's actual participation in consultations. Protective orientations should therefore be regarded not as an obstacle to child-centered care but as a starting point for clinical communication.

The negligible contribution of the sociodemographic block, which supported H2 and was robust across the sensitivity analyses, directs attention away from demographic stratification and toward less easily measured correlates of parents' willingness to support children's participation.

By contrast, adding the two remaining

attitudinal subdimensions substantially increased the explained shared variance, supporting H1. Attitudinal dimensions toward children's rights are therefore not entirely independent constructs but co-vary within a single rights-based framework, consistent with reports that such attitudes develop as a holistic structure.[13] In the original development study, these subdimensions showed very weak correlations (r = 0.04 and −0.007), suggesting that the magnitude of shared variance observed in the present sample may not be attributable solely to their inclusion within the same instrument.[11] These findings are descriptive rather than causal (see Limitations).

That State Assurance and Support showed the strongest association with Self-Determination is notable: parents who view the child as a rights-bearing individual may regard both institutional obligations and the child's right to participate more favorably. Expressing the child's voice is not sufficient; it must also be heard and reflected in decision-making.[15] The positive association between Care and Protection and Self-Determination is equally relevant: within a rights-based framework protection and participation are not mutually exclusive and may be held simultaneously.[2]

That maternal education was related to Care and Protection but not to Self-Determination suggests that the association between education and attitudes toward children's rights may be dimension-specific. Higher educational attainment may increase awareness of the child's protection needs, although the small effect size indicates limited practical significance. Attitudes toward children's participation may instead relate to more deeply rooted factors such as cultural norms, conceptions of childhood and family authority structures.[16-18] The observed association may point to domains that future parental education or health-literacy interventions could address, although no intervention was evaluated here.

Involving children in medical decision-making, informing them and obtaining their views are core components of pediatric care,[13] yet shared decision-making is not yet well established in routine practice, with barriers and facilitators at the parent, child and professional levels.[19] Structured communication models that address the child directly and incorporate the child's preferences into the encounter may therefore be useful.[13,20]

Limitations

Several limitations should be taken into account. As regards internal validity, the variables entered in the model and the outcome were subdimensions of the same instrument, and the two nurturance subdimensions were not empirically separable once measurement error was taken into account (disattenuated r = 0.98); the Block 2 increment therefore reflects shared variance within a single scale, the coefficients carry no causal meaning, and the cross-sectional design precludes any inference about direction. The study also measured attitudes rather than observed parenting behavior or children's actual participation in consultations, and maternal and paternal attitudes were analyzed jointly under the single category of "parent" although they may differ.

As regards generalizability and the scope of the conclusions, data came from a single tertiary center and 40.3% of the parents invited declined; because no data were collected from them, neither the magnitude nor the direction of non-response bias can be estimated, and parents more sympathetic to children's rights may have been more willing to take part, biasing the subdimension scores—particularly Self-Determination—upward. The sample was also relatively highly educated (46.0% of mothers and 49.1% of fathers were university graduates), the small literate-only subgroup (n = 6) restricts inference for that group, and the instrument was standardized on parents of children aged 6 to 14 years, whereas participating parents had children aged 1 to 18 years, so its fit to parents of the youngest and the oldest children may be imperfect. Children were not stratified by age or developmental stage, so clinical applications such as confidentiality in adolescence or the gradual transfer of treatment responsibility in chronic illness should be read as potential implications requiring age-stratified investigation rather than as findings of this study. Taken together, the results describe the attitudinal profile of the parents who chose to participate at a single center; they do not establish population prevalence, causal ordering, or the effect of any clinical practice. Future studies should assess child participation and clinical decision-making with different instruments, observational data and age-stratified designs.

CONCLUSIONS

Among parents attending a pediatric outpatient clinic, Care and Protection and State

Assurance and Support scored high, whereas Self-Determination showed the lowest mean. Sociodemographic variables contributed little to Self-Determination, while the other two subdimensions shared substantial variance with it within the same instrument; these relationships describe attitudinal co-occurrence rather than causal determinants. These findings support the importance of creating opportunities for children to participate in pediatric care in ways appropriate to their age and developmental level. Because attitudes were measured rather than clinical practice, and because children were not stratified by developmental stage, applications such as confidentiality in adolescence or the gradual transfer of treatment responsibility in chronic illness are best regarded as implications to be examined in age-stratified studies rather than as recommendations demonstrated by the present data. ■

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The supplementary material provided with this article is presented as submitted by the authors. It is available at: https://www.sap.org.ar/docs/publicaciones/archivosarg/2027/11255_AO_Cambaz_Kurt_Anexo.pdf

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