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Welcome to the fourth issue for 2014. We receive articles from many parts of the world and some do not make it into the journal. This is mainly due to our focus on young people and, although we do not specify an age range, most published articles are about those between the ages of 5-20 years old. There are exceptions and the Editor welcomes your contribution.

This issue continues with the proud tradition of independent publishing and offers an eclectic mix. The journal, published since 1983, is aimed at those involved with education and health who are concerned with the health and wellbeing of young people. Readers, in the UK, come from a broad background and include: primary, secondary and further education teachers, university staff, and health-care professionals working in education and health settings. Readers outside of the UK share similar backgrounds. The journal is also read by those who commission and carry out health education programmes in school and college.

Articles focus on recent health education initiatives, relevant research findings, materials and strategies for education and health-related behaviour data.

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Shirley Horton has recently retired from teaching after forty years.

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Shirley A Horton

Forty years of change: developments in health education in schools and future challenges

I have recently retired from teaching and this article describes some of my reflections on the past forty years of developments in schools health education and some challenges for the future.

During my career I have fulfilled a number of pastoral roles in the three schools I have worked in and have seen and experienced the impact of a wide range of initiatives aimed at guiding students to make informed choices in their own lives.

Nitty Nora

My own experiences of being on the receiving end of health education at school are very limited. We had regular visits from the school nurse, aka Nitty Nora the bug explorer, the school dentist and the formidable school medical. Apart from that I cannot recall any input from the teachers on health issues until I was in the secondary school. Starting puberty and the dreaded periods at nine years old, it seemed junior schools were just not geared up for this and being “special” meant that the two of us, who were “grown up”, could use the teacher’s toilets which led to intense questioning from our fellow pupils.

My parents were not very forthcoming about health issues, this being the time of baths once a week in a tin bath by the fire and filling up on cheaper carbohydrate foods and eating it all up so you could have pudding. Central heating did not exist and suet puddings and dumplings were required for energy and warmth. Short socks were the order of the day and I can still recall the odour of damp wool gloves, scarves and balaclavas drying on the metal cage surrounding the open fire in the classroom. Chilblains were another winter complaint which we do not hear about today. Another unpleasant memory was warm school milk which had spent all day on the mantelpiece ready to reward girls and boys who had worked hard. I have never liked warm milk since then, it’s much better icy cold straight from the crate on a winter’s day. If we were lucky, we got the milk before the blue tits pecked the cream off.

Health issues

From an early age I was actively interested in health issues. My auntie was an infant teacher and I can recall reading books about the health of the school child and looking at textbooks with the importance of outdoor play and PE for development. I was intent on becoming a teacher from an early age and could see that health was important if children were to do well at school. My own attendance at school was not very good having had most of the childhood illnesses quite badly in the junior school and having a period of time with pneumonia. I have always had problems with decimals ever since as I missed the block of lessons where the mysteries and rules were explained.

At Grammar school, I followed a very academic curriculum, there was no time for PSHE: the prefects dispensed the discipline out of the classroom and there was bullying and teasing. The teachers seemed very remote, sitting in their gowns at high desks, so the thought of telling anyone about being unhappy at school or about being bullied just didn’t enter my mind. The attitude at home was to stand up for myself, not to allow myself to be put down and to smack someone if necessary!

It wasn’t until we had a new head of sixth form who was keen on pastoral welfare that I began to blossom. The last two years in the
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upper school were really happy and, as a prefect, I took part in a pioneering project to help younger students to settle in to the school and worked in an anti-bullying group. This made me realise that I really did want to be a teacher and I decided to train at Totley Thornbridge College in Sheffield to teach Home Economics. This in itself was a battle as school thought I was underselling myself and should be following a much more academic course. I suppose today we would talk about not reaching my potential!

Health education

The course I followed, with Health Education as an option, really set me up for working in schools in the late 1970’s. This was a period of great change and saw the first of the developments in the teaching of health issues in schools. Poor personal hygiene was an issue in many of the schools I did teaching practice in. Many of the pupils came from homes without an inside bathroom and toilet and the regular changing of clothes and washing of hair was seen as an important part of the Home Economics curriculum. Many rooms still had a “flats experience” area and girls did come and have baths at lunchtime and talk about period problems and concerns.

All of the teachers I worked with at this time saw their job as having a strong pastoral role in the welfare of the pupils in their care and they dispensed a lot of tea and sympathy as well as making sure that children had a proper meal as many came to school without breakfast or change to buy some lunch. They were all good listeners and were very perceptive about the true reasons behind some of the health issues.

The teaching of sex education was also a new development and I still blush at some of the first lessons I taught on teaching practice. Thinking back, I wasn’t much older that some of the pupils and they certainly knew a lot more than I did! We had only done about rabbits, rats and birds at school! Forward-thinking schools included this as a topic in the new fifth year for the school leavers. The school leaving age changed in 1972 and preparation for adulthood led to new courses about being responsible and parent craft. As you can imagine, most teachers were not rushing to teach the subject matter and much of it was left to the Home Economics department, R.E or P.E. Depending who was teaching the course, the message varied but, in most cases, it was “don’t do this otherwise you will end up pregnant”. There was no attempt to explain about contraception and its careful use. Kits showing examples did not exist and despite all you hear about the swinging sixties and seventies the “Pill” was not always easy for single women to get. The emotional side of relationships was not explored and choosing carefully and not sleeping around was the main message. Venereal disease was seen as something that people got as a punishment for being promiscuous. There was little or no discussion about the age of consent or what consent actually meant or respect or negotiation. It was basically a case of “nice girls don’t”. It is interesting to compare with today where mixed-sex groups are empowered in the classroom and prepared for real life by discussing issues and role-playing condom-use negotiation situations.

First job

My first job was at a school in Leicestershire. This opened up lots of new challenges for me as a young Home Economics teacher. The school roll seemed to grow each day as we accepted the children of families fleeing from the purges of Idi Amin in Uganda. In a traditional cookery course, there were not many dishes which would adapt easily. Not touching or eating eggs during their menstrual cycle was a particular issue for some of the girls which made making even the simplest of cakes difficult. The health needs of students were well provided for and there was an emerging PSHE course which I quickly became involved with. The Senior Mistress told me it would be a good career opportunity and soon I was involved in negotiations with religious leaders and families about a new series of lessons on tape called “Living and Growing”. This series of lessons was a big improvement on some of the Scandinavian tapes I had used previously with older pupils. In many of these films, orgasm was shown with the couple in the sea or with waves breaking on the beach. I often
wonder how many pupils went away thinking that if you bathed in the sea you could get pregnant, as often the next frame showed a pregnant woman at the antenatal class.

It was an interesting time for me as a young teacher as I built up my own knowledge of different cultural practices and beliefs about menstruation and F.G.M as well as doing battle with a massive piece of new technology called the video recorder. This was the most frightening piece of kit I had ever used, it was expensive, locked up in a big cabinet and had reel-to-reel tape system. It was always a relief to me when the lesson ended and the tape rewound and didn’t break!

The next twenty years at a secondary school in the Lincolnshire Fens was a very busy time for me personally and saw a massive number of health education initiatives which were exciting and moved towards what we would regard as good health education practice today. I was fortunate to develop close links with our feeder primary schools, the school nurse, social services, the police and the Lincolnshire Health promotion team.

The school valued the importance of PSHE and I was lucky to be able to go on courses to supplement my own subject knowledge and to try out new resources in the classroom. As well as sexual health, another local issue was the need for more effective drugs education. Much of the early work and publicity relied upon shock tactics and “if you do this you will die”.

Nowadays we teach youngsters the skills to resist the temptations, to have good self-esteem and to deal with peer pressure. Smoking, particularly amongst girls, and use of alcohol remain big challenges as the cost to the N.H.S increases. The importation and dealing of drugs in the local area was a concern as we were served by three ports with links to the continent and there were regular seizures of drugs.

**Time restrictions**

During this time I worked with a group of teachers at County level and we undertook to design and make resources for use in school and to organise and run active learning courses for teachers. This was an exciting time for me and I was fortunate to be allowed time out of school to do this. This is an issue that concerns me today as there is so little time in the busy curriculum to develop new courses and to allow inexperienced teachers to go on courses to develop their own subject knowledge so that they approach teaching PSHE with confidence in the classroom. This was particularly evident when teaching about HIV/AIDS where many staff found their own prejudices about homosexuality caused difficulties in openly discussing condoms and alternative sexual practices. This was the turning point for health education in that issues needed to be tackled which had previously been hidden.

Working with parents can be both difficult and rewarding. Most parents are very happy to hand over the teaching of sexual issues to teachers that they trust as it saves them from embarrassment and within a well-planned spiral curriculum there is an opportunity to develop a range of approaches to build upon previous knowledge at a time appropriate to the age and maturity of the class. However, some parents do exercise their right to look at resources and to even withdraw their child from lessons. This is often fuelled by inaccurate reporting by the media and in most cases I found that parents who did raise concerns were reassured once they saw what you were going to cover in lessons.

**Parent health evenings**

One of the most successful ways of getting parents on board with what you wish to cover is by having regular parents “health evenings” as part of a friends of the school programme. Drugs is always a good topic to start with as this is perhaps the topic that parents worry about the most. Active evenings where parents try out the activities done by the pupils are always the best as they are hands on and give the opportunity for discussion. Parents often express their surprise about how open students are in their questions, forgetting that they would soon jump to conclusions if the questions in the classroom were raised at home.

**The “sex lady”**

One of my most embarrassing moments occurred as a result of some sessions I had been running in local primary schools on puberty. I was out with my husband in a busy restaurant
when a man shouted across the table “I know you”. I said, perhaps he was mistaken, and carried on eating my meal. A few minutes later he said, “Yes, I do know you, you are the sex lady!” Try explaining that one as nearly everyone in the restaurant seemed to turn around and stare at me.

I have always believed that good quality PSHE underpins the whole school and that it is important for governing bodies and Head teachers to find quality time in the curriculum for lessons for every year group. I have been fortunate to work for some excellent management teams who have also shared the vision that health education is vital. One of my biggest bugbears in education is that schools are always being criticised for not doing things. Most of the people criticising have never been in a school since they were educated themselves and they have little knowledge of the sterling work being done by teachers day to day in the classroom. Every school is different and it is really important to get to know your catchment area and local neighbourhood. Another useful tool, particularly if you are re-designing your PSHE curriculum is to use the confidential surveys, developed by SHEU, with your students. These give you a really good picture of your school and the topics that students are needing information on and are a good methods of getting the message over to curriculum leaders. With consultation and a good choice of staff to deliver the lessons, a wide range of issues can be covered through subjects like English, Drama and R.E.

Good staff, who are willing to teach the subject, are very important if you are to deliver the topics well. Too many schools use free lessons on the timetable to make up their PSHE team, this is very short-sighted as it is so important to have a good team of teachers who feel relaxed talking about and discussing a variety of issues

**Curriculum development**

Another useful tool, for teachers of Health Education, are the reports on local authority areas and the health issues. These give you a good picture of the key concerns in the local area and information about initiatives taking place in the local community. By using these, you can tailor your curriculum in school and really make a difference. In 2001, I moved to South Derbyshire and had to design a relevant curriculum from scratch. From the reports, I discovered that the key issues were Teenage pregnancy, high rates of death from cancer and heart disease and smoking and alcohol issues amongst young people, as well as the whole community, and Domestic Abuse. This gave me a focus on which to base my curriculum and soon we were involved in local projects which attracted national attention in the press and funding to develop new work through “Theatre in Education”[TIE]. Sadly many of these initiatives were subject to Government cuts in recent years.

Quality TIE performances were a powerful vehicle to get difficult situations across to pupils and staff. Another interesting project was “Blueprint for Drugs” which paid for high quality training for non-specialist teachers and provided a two year cycle of lessons on drugs related issues.

However, statistics should be used carefully, the media are always keen to jump on teenage pregnancy figures, totally disregarding the fact that these include mothers in secure married and cohabiting relationships up to the age of 19 and many of the new mums are not schoolgirl mums at all!

Sadly, funding at national and local level often dries up when you have shown improvements and something else becomes high priority. One of the most frustrating things for me was when we had successfully negotiated the provision of emergency contraception in the local area and a weekly “clinic” was held to provide a service for older students to access contraception from the local nursing team. The figures reported in the local paper showed a massive downturn. The result being that funding was withdrawn so the facility had to close and the original problems escalated again.

**Scratching the surface**

As I look back over the past 40 years, I feel that the teaching of health education teaching so far has only scratched the surface. It is one of the most important subjects in school and still some schools are doing very little to meet the needs of
their pupils. Forty years is a very short period of time to effect a massive change in society and there will always be approaches and initiatives that do not work or have the results that were intended.

As I see it, the challenges for teachers of the future are to continue to address the needs of their students and to provide teaching and opportunities for young people to make informed choices for their lives. In the few weeks I have been retired, the media has been full of issues which need to be addressed by a broad and balanced spiral health curriculum. Girls and increasingly boys are dogged by issues to do with self-esteem and eating disorders. Many of these issues are fuelled by the Internet and the various types of Cyberbullying. The cases of Chlamydia are soaring amongst young people and obesity is at crisis level. Young people are still drinking too much alcohol despite all of the measures to counteract underage drinking and more girls are taking up smoking despite the high cost of cigarettes. Vaping using electronic cigarettes is the newest challenge and the use of legal highs remains a problem. It seems that there is a need for even more health education provision to aid young people in developing the skills to make decisions in their everyday life.

In conclusion, as I look back through this article, I have missed out so many issues that I could have covered which are of equal importance to the ones I have briefly mentioned. As a society there will always be new challenges to face and by nature we are curious and want to take risks. Preparing and guiding young people to meet these challenges head on and to make healthy and appropriate decisions for their future health remains a challenge for the teachers and dare I say it - the parents of the future.

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**Education and Health**

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Gaming addiction has become a topic of increasing research interest. Over the last 25 years, I have written many articles on adolescent video gaming for *Education and Health* as it is one of the research fields that is constantly evolving. In fact, over the last decade, there has been a significant increase in the number of scientific studies examining various aspects of online addiction particularly among adolescents and young adults (Kuss & Griffiths, 2012; Kuss, Griffiths, Karila & Billieux, 2014). Although the amount and the quality of research in the field has progressed much over this period, it is still in its infancy compared to other more established behavioural addictions (such as pathological gambling). This article briefly examines (i) how adolescent gaming addiction research has changed over the last three decades, (ii) how online gaming addiction has gained genuine psychiatric status, (iii) excessive gaming as an addiction, and (iv) where the gaming addiction field is going.

**How has adolescent gaming addiction research changed?**

In the 1980s, research mainly concerned adolescents playing ‘pay-to-play’ arcade video games. In the 1990s, research mainly concerned standalone (offline) video games played by adolescents at home on consoles, PCs or handheld devices. In the 2000s, research mainly concerned the playing of Massively Multiplayer Online Role Playing Games (MMORPGs) by both adolescents and adults. Over time, there has been less of an emphasis on research involving pure adolescent samples with increasing research on older samples (particularly young adults and university students). Estimates of the prevalence of problematic and/or addictive gaming use among those aged 10 to 17 years are typically between 2% and 5% although some studies have reported much higher prevalence rates particularly among those that actually play video games as opposed to general adolescent populations (Kuss & Griffiths, 2012).

There has also been a noticeable shift in how gaming addiction data are collected and this has had an impact on the number of research studies carried out on adolescent gaming. Up until the early 2000s, data about problematic gaming were typically collected face-to-face in schools, whereas contemporary studies tend to collect data online, strategically targeting online gaming forums where gamers are known to (virtually) congregate. The decrease of data collection in schools has clearly contributed to the decrease in adolescent-only gaming studies. These online samples are typically self-selecting and (by default) unrepresentative of the adolescent and/or general population. Therefore, generalization is almost always one of the methodological shortcomings of this data collection approach. As a direct consequence of changing the way data are collected, survey study sample sizes have generally increased. In the 1980s and 1990s, sample sizes were typically in the low hundreds and came from one school. In the 2000s, sample sizes in their thousands – even if unrepresentative – are not uncommon.

Finally, there has been a diversification in the way data are collected including experiments, physiological investigations, secondary analysis of existing data (such as that collected from online forums), and behavioural tracking studies. These newer research methods are also less likely to include adolescent samples because ethical approval for participant recruitment in experiments and physiological investigations is typically easier. Behavioural tracking studies tend to involve data from gaming operators where the minimum age is typically 18 years. Finally, there has also been increased research on adult (i.e., non-child and non-adolescent)
samples more generally reflecting the fact that the demographics of gaming have changed and that the typical gamer is no longer a male teenager but a male in his late twenties or early thirties.

The medicalisation of online gaming addiction

Prior to the publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), there had been some debate as to whether ‘Internet addiction’ should be introduced into the DSM text as a separate disorder (Petry & O’Brien, 2013). Alongside this, there were also debates as to whether those researching in the online addiction field should be researching generalised Internet use and/or the potentially addictive activities that can be engaged on the Internet (e.g., gambling, video gaming, sex, shopping, etc.) (Griffiths, 2000) and whether adolescent gaming addiction is conceptually or functionally any different from adult gaming addiction.

Following these debates, the Substance Use Disorder Work Group (SUDWG) recommended that the DSM-5 include a sub-type of problematic Internet use (i.e., ‘Internet Gaming Disorder’ [IGD]) in Section 3 (‘Emerging Measures and Models’) as an area that needed future research before being included in future editions of the DSM (Petry & O’Brien, 2013). There were no exclusion criteria relating to age (i.e., adolescents fulfilling the criteria are no different from adults clinically). According to Petry and O’Brien (2013), IGD will not be included as a separate mental disorder until the (i) defining features of IGD have been identified, (ii) reliability and validity of specific IGD criteria have been obtained cross-culturally, (iii) prevalence rates have been determined in representative epidemiological samples across the world, and (iv) aetiology and associated biological features have been evaluated. I would also add that adolescents are a particular group at risk for developing such problems and that research should routinely include adolescent subsamples.

One of the key reasons that IGD was not included in the main text of the DSM-5 was that the SUDWG concluded that no standard diagnostic criteria were used to assess gaming addiction across these many studies. A recent review of instruments assessing problematic, pathological and/or addictive gaming by King and colleagues (2013) reported that 18 different screening instruments had been developed, and that these had been used in 63 quantitative studies comprising 58,415 participants (and even more instruments have been developed since). This comprehensive review identified both strengths and weaknesses of these instruments.

The main strengths of the instrumentation included: (i) the brevity and ease of scoring, (ii) excellent psychometric properties such as convergent validity and internal consistency, and (iii) robust data that will aid the development of standardised norms for adolescent populations. However, the main weaknesses identified in the instrumentation included: (i) core addiction indicators being inconsistent across studies, (ii) a general lack of any temporal dimension, (iii) inconsistent cut-off scores relating to clinical status, (iv) poor and/or inadequate inter-rater reliability and predictive validity, and (v) inconsistent and/or dimensionality.

Excessive gaming as an addiction

Video gaming that is problematic, pathological and/or addictive lacks a widely accepted definition. A recent review by Pápay and colleagues (2014) argued that some researchers consider video games as the starting point for examining the characteristics of this specific disorder, while others consider the Internet as the main platform that unites different addictive Internet activities, including online games. Again, no differentiation is made between adolescents and adults that play video games problematically. Recent studies (Demetrovics et al., 2012; Kim & Kim, 2010) have made an effort to integrate both approaches Consequently, IGD can either be viewed as a specific type of video game addiction, or as a variant of Internet addiction, or as an independent diagnosis.

I have argued that although all addictions have particular and idiosyncratic characteristics, they share more commonalities than differences (i.e., salience, mood modification, tolerance,
withdrawal symptoms, conflict, and relapse), and likely reflects a common aetiology of addictive behaviour that often begins in adolescence (Griffiths, 2005). Consequently, online game addiction is viewed as a specific type of video game addiction. Similarly, Porter and colleagues (2010) do not differentiate between problematic video game use and problematic online game use. They conceptualised problematic video game use as excessive use of one or more video games resulting in a preoccupation with and a loss of control over playing video games, and various negative psychosocial and/or physical consequences. Researchers such as Young (1998) view online gaming addiction as a sub-type of Internet addiction and that the Internet itself provides situation-specific characteristics that facilitate gaming becoming problematic and/or addictive. This is potentially important in relation to online gaming addiction in that research tends to show that minors are more at risk from developing problems online than adults (Kuss et al., 2014).

Irrespective of approach or model, the components and dimensions that comprise online gaming addiction are very similar to the IGD criteria in Section 3 of the DSM-5. For instance, my six addiction components (Griffiths, 2005) directly map onto the nine proposed criteria for IGD (of which five or more need to be endorsed and resulting in clinically significant impairment). More specifically:

1. Preoccupation with Internet games [salience]
2. Withdrawal symptoms when Internet gaming is taken away [withdrawal]
3. The need to spend increasing amounts of time engaged in Internet gaming [tolerance]
4. Unsuccessful attempts to control participation in Internet gaming [relapse/loss of control]
5. Loss of interest in hobbies and entertainment as a result of, and with the exception of, Internet gaming [conflict]
6. Continued excessive use of Internet games despite knowledge of psychosocial problems [conflict]
7. Deception of family members, therapists, or others regarding the amount of Internet gaming [conflict]
8. Use of the Internet gaming to escape or relieve a negative mood [mood modification]
9. Loss of a significant relationship, job, or educational or career opportunity because of participation in Internet games [conflict]

The fact that IGD was included in Section 3 of the DSM-5 appears to have been well received by researchers and clinicians in the gaming addiction field (and by those adolescents and adults that have sought treatment for such disorders and had their experiences psychiatrically validated and feel less stigmatized). However, for IGD to be included in the section on ‘Substance-Related and Addictive Disorders’ along with ‘Gambling Disorder’, the gaming addiction field must unite and start using the same assessment measures so that comparisons can be made across different demographic groups (including adolescents) and different cultures.

For epidemiological purposes, Koronczai and colleagues (2011), asserted that the most appropriate measures in assessing problematic online use (including Internet gaming) should meet six requirements. Such an instrument should have:

1. Brevity (to make surveys as short as possible and help overcome question fatigue)
2. Comprehensiveness (to examine all core aspects of PAP gaming as possible)
3. Reliability and validity across age groups (e.g., adolescents vs. adults)
4. Reliability and validity across data collection methods (e.g., online, face-to-face interview, paper-and-pencil)
5. Cross-cultural reliability and validity
6. Clinical validation

It was also noted that an ideal assessment instrument should serve as the basis for defining adequate cut-off scores in terms of both specificity and sensitivity.

The good news is that research in the gaming addiction field does appear to be reaching an emerging consensus. King and colleagues (2013), noted that across many different studies, IGD is commonly defined by (a) withdrawal, (b) loss of control, and (c) conflict irrespective of the age of gamers. However, it is critical that a unified approach to assessment of IGD is
urgently needed as this is the only way that there will be a strong empirical basis for IGD to be included in the next DSM.

Where is the gaming addiction field going?
Finally, this section provides a considered (and somewhat speculative) examination of what might happen in the gaming addiction field from a number of different standpoints (e.g., methodological, conceptual, technological).

Better instrumentation
Given the many different screening instruments that have been developed over the last decade, there is likely to be a refinement of video game addiction measures and greater consensus on its conceptualisation, either as a single disorder and/or incorporated into other known disorders (e.g., impulse control disorder). This is also likely to lead to improved assessment tools based on such conceptualisation(s). For instance, my colleagues and I have just developed a new instrument specifically based on the new IGD criteria in the DSM-5 (see: Pontes, Király, Demetrovics & Griffiths, 2014). In the last few years, instruments have been developed that have more robust psychometric properties in terms of reliability and validity. However, there are still some concerns as many of the most widely used screening instruments were adapted from adult screens and much of the video game literature has examined children and adolescents.

Increased gaming diversification
Measures of gaming use and subsequent behaviour are likely to diversify in terms of media use, including social networking sites (SNS) and associated Internet resources (Griffiths, Kuss & King, 2012). Already, games such as Call of Duty and Battlefield 3 are being released with their own SNS (e.g., COD Elite) that track player behaviour and provide feedback to players as to how to improve their game (thus functionally reinforcing video game play and thus have implications for excessive and/or potentially addictive play). Many of these newer online media – particularly social networking sites – are heavily used by adolescents (Griffiths, Kuss & Demetrovics, 2014) and is why adolescent samples need to be continually monitored in this area.

Increased monetisation of games
Given the pressure on media enterprises to ‘monetize’ their business and look for different revenue streams, there is likely to be even greater media convergence between gaming and other more profit-making activities such as gambling (Griffiths, King & Delfabbro, 2014). Given the well established addictive potential of gambling, this may also have implications for the incidence of gaming addiction among both adolescents and adults (Griffiths et al., 2012).

Increased feminisation of gaming
Given the fact that the Internet is gender-neutral, there is likely to be increasing feminisation of gaming where increasing numbers of females not only engage in the playing of online games, but also develop problems as a result. Casual gaming online is already popular among females (Lewis & Griffiths, 2011; McLean & Griffiths, 2013). However, the biggest difference between male and female gaming is likely to be content-based (e.g., research has shown that teenage males prefer competitive type gaming experiences whereas teenage females appear to prefer cooperative type gaming experiences) (Griffiths, Davies & Chappell, 2004).

Increased collaboration between researchers and the gaming industry
Given the increasing number of research teams in the gambling field being given direct access to gambling companies’ behavioural tracking data, there is likely to be an increasing number of such collaborations in the gaming studies field in which actual online micro-data can be analysed. This may mean adolescent samples are neglected in such research, as many such sites require credit card subscriptions and/or require clients to be adult.

Improved and more innovative treatment
As the diagnosis of video game addiction becomes more legitimate in psychiatric and medical circles, it will lead to improved randomized control trials on interventions for problematic video game play than the ones already carried out. There is also likely to be an increase in the online medium itself being used as a treatment channel. The reasons that people like to engage in some online leisure activities (i.e., the fact that the online environment is non-face-to-face, convenient, accessible, affordable,
anonymous, non-threatening, non-alienating, non-stigmatising, etc.) may also be the very same reasons why people would want to seek advice, help and treatment online rather than in face-to-face situations. There is also some evidence that teenagers (particularly adolescent boys) would be more likely to access online services when they have problems rather than seek out face-to-face help, guidance and/or counselling (Wood & Griffiths, 2007).

Conclusions

Clearly, there are knowledge gaps in current understanding of problematic video game play and video game addiction in both adolescent and adult populations. The number of studies into adolescent gaming addiction may further decrease over time given the way in which data is now typically collected and the fact that playing video games is no longer the sole domain of male teenagers. However, there is still a need for epidemiological research to determine the incidence and prevalence of clinically significant problems associated with video game play both adolescents and in the broader population. This needs to include both children and adolescents so that video game playing and potentially problematic play can be studied in a longitudinal and developmental context.

There are too few clinical studies that describe the unique features and symptoms of problematic video game play and/or video game addiction. There may well be differences between adolescents and adults as to whether gaming is seen as problematic – especially as context is an important determinant of whether something is viewed as problematic, and adolescents are likely to have much more flexibility and time available to play video games than adults (Griffiths, 2010). While the current empirical base is relatively small, gaming addiction has become a more mainstream area for psychological and psychiatric research. Adolescent gaming addiction is likely to become an area of significant importance given the widespread popularity of gaming among the current adolescent population (Kuss & Griffiths, 2012).

References


In the UK it is recommended that men and women not regularly exceed 3-4 units or 2-3 units of alcohol per day, respectively; these are the ‘lower risk daily guidelines’ (Drinkaware, 2014). Binge drinking is defined as exceeding twice these guidelines on one drinking occasion (Department of Health, 2003). Reducing the number of people engaged in this behaviour is a key action in the current national alcohol policy (Department of Health, 2013).

In 2011, 22% of males and 18% of females age 16-24 years old reported binge drinking (Office for National Statistics, 2013), but higher figures have been reported among the student population. In a recent study of seven UK Universities, 65% of female and 76% of male students reported binge drinking in the previous two weeks (El Ansari et al., 2013). This drinking pattern in early adulthood can impact on current and later health (Rehm et al., 2003) as binge drinkers at this age are more likely to become harmful, steady drinkers in later adulthood (Mathurin and Deltenre, 2009). It can also have adverse social consequences, increasing the risk of accidents and violence resulting in injury (Rehm et al., 2003), and may impact upon academic performance (Howland et al., 2010).

This study sought to explore the need and opportunities to manage binge drinking among undergraduates at a large university in the south of England. In addition, we sought to create tailored recommendations to tackle alcohol-related harm and encourage sensible drinking practices.

Methods
Study design and participants
Students and staff at the University were purposively sampled to capture the opinions of relevant individuals. This included undergraduate students in their first year of study, club executives (undergraduate students with a leadership role in University sport clubs) and members of staff involved in student welfare (Hall of Residence wardens, student services) and the Students’ Union (SU). Undergraduate students from a large Hall of Residence were invited to take part in a focus group discussion; three students participated. Club executives, who were identified on the SU website, and staff were sent an email invitation to take part in a face-to-face or telephone interview. Of 61 club executives and 18 service providers contacted, seven and nine, respectively, from different sport clubs and university departments consented to be interviewed.

Data collection
Separate semi-structured topic guides were developed for the students, club executives and staff. Topic guides focused on participants’ understanding of and attitude toward binge drinking, perceived influences on student drinking and opinions of (current and potential) efforts to help them reduce their alcohol intake. Students and club executives were also asked about their drinking behaviour, knowledge of the consequences, and importance of alcohol when socialising. As only a few students attended the focus group, the students’ topic guide was adapted into a ten question online survey with open-ended questions to elicit detailed responses from students. This was posted on the University’s SU and sport club social media pages. Eleven people responded to the survey.

Participants gave written consent after being informed that data would be anonymised and they were free to withdraw at any time.
Participants of the online survey were informed beforehand that by taking part they gave their consent. The focus group and interviews were conducted by AT and digitally audio-recorded.

**Data analysis**

The focus group and interviews were transcribed verbatim by AT and thematically analysed (Braun and Clarke, 2006), using NVivo 9 as a data management tool. Survey data were combined with the transcripts. Initial themes were identified using the topic guides, and transcripts were then read several times from which remaining themes were generated. Three transcripts were coded independently by both authors, differences were discussed and resulting codes were agreed and applied to the remaining transcripts.

Data from all groups, i.e. students, club executives and staff were analysed together and the results presented reflect them all. Club executives and students views are presented together, unless otherwise stated.

**Ethical approval**

The study was approved by the University Of Southampton Faculty Of Medicine Ethics Committee.

**Results**

The analysis identified four themes: (1) attitudes and behaviour toward binge drinking, (2) influences on drinking behaviour, (3) non-drinking at the University and (4) managing binge drinking.

**Attitudes and behaviour toward binge drinking**

Many students acknowledged that they engaged in heavy drinking sessions as illustrated in Figure 1, 1a. Such sessions were reported to be frequent and often facilitated by drinking cheaper drinks at home before going to a bar or club. However, respondents did not associate this behaviour with binge drinking. Typically they defined binge drinking as consuming very large quantities of alcohol or ‘problem drinking’ (Figure 1, 1b); although a few associated it with exceeding the recommended daily limit.

Some staff felt many students drank heavily and this was dangerous, but admitted they were not aware of the extent of drinking at the University. A few queried whether there was a problem.

Students tended to focus on social consequences when discussing the risks of drinking and had limited knowledge of the health effects. They were not seen as a reason to not drink (Figure 1, 1c). Additionally, some students perceived that first year students tended to drink heavily and they grew out of this behaviour (Figure 1, 1d).

**Influences on drinking behaviour**

Drinking was seen as a normal part of students’ social life. Many participants said that in coming to university, students were entering a new environment where they had the freedom to choose their social activities and how much to drink. Students also said socialising with alcohol was a way to fit in and gave them the confidence to make friends (Figure 2, 2a).
Drinking was common in many sport clubs. Many club executives ranked drinking as an important part of their social activities. One staff member described how initiation ceremonies into sports clubs focused on heavy drinking and drinking challenges. Some sport clubs, however, actively discouraged or did not centre their social activities on drinking (Figure 2, 2b). Some staff highlighted their concerns about the promotion of and pressure to engage in binge drinking by Junior Common Room (JCR) representatives. They felt these older students, responsible for first year students’ welfare, had a large influence on drinking behaviour (Figure 2, 2c), although this was not raised or discussed by students.

Staff believed that many students were pressurised to drink by friends, which was acknowledged by students (Figure 2, 2d). However, one student who had told peers they did not want to drink heavily said they had not faced pressure over this decision.

The ease of access to alcohol on and off campus was also thought by students and staff to be an important influence on the frequency and amount of drinking. Accessibility was manifested through the large number of drinking venues and low price of alcohol (Figure 2, 2e).

Non-drinking at the University

Club executives and university staff noted that some students were intimidated by, and therefore excluded from, the large number of social activities involving heavy drinking (Figure 3, 3a).

Events where alcohol was not available or the sole focus, such as the SU cinema and comedy nights, were offered to students. The majority of staff, however, felt that not enough were available compared with the number of alcohol-focused events (Figure 3, 3b). Club executives reported that sports clubs are required to hold at least three alcohol-free socials per year yet, despite some having considerably higher attendance at these events than alcohol socials (Figure 3, 3c), they tended to occur less regularly. Moreover, these were not strictly enforced by the SU.
Managing binge drinking

University-based interventions focused on preventing adverse social consequences, such as a ‘get home safe’ scheme. No interventions were in place to prevent students from binge drinking, although staff and some students felt this was warranted (Figure 4, 4a). Alcohol awareness campaigns highlighting the dangers of heavy drinking had been run previously, but none were active at the time of this study. Students felt that the national awareness campaigns they had seen did not influence their behaviour because they were not relevant to them or they already knew the risks. None of the current (non-alcohol socials, get home safe scheme), or previous (awareness-raising) interventions had been monitored to determine their effectiveness.

Many participants felt that creating an environment that was not conducive to drinking through the provision and promotion of alcohol-free social events was important. The few available events were pointed out as being very popular. The University appeared to be supportive of and were seen to be making some progress in hosting more alcohol-free events (Figure 4, 4b). A few participants, however, felt there were either enough already available, or that they would segregate drinkers and non-drinkers.

Students and SU staff said the SU should have a lead role in future initiatives. Non-SU staff reported they too had an important role and that a collaborative effort across departments was needed. Despite this, no staff members were aware of efforts to manage binge drinking in other parts of the University (Figure 4, 4c) and some talked about the limited time they had to focus on this issue. One discussed the importance of involving students in developing future interventions, who also highlighted they would prefer not to be told what to do, and anything developed should be relevant to them.

Discussion

The majority of students that took part in this study binge drank, consistent with quantitative data on undergraduates’ drinking behaviour (El Ansari et al., 2013), but they did not associate this behaviour with binging. Moreover, they did not believe they should reduce their alcohol intake. Factors that influenced drinking behaviour were peer pressure, peer drinking and the abundance of drinking events. It has been noted that peer pressure predicts binge drinking and total weekly alcohol consumption (Jamison and Myers, 2008). Students in the study reported here who preferred not to drink or engage in binge drinking could feel isolated due to these influences and the dearth of alcohol-free events.

That many students in this study did not relate the term ‘binge drinking’ to their own behaviour, which has been reported previously (Orford et al., 2004), suggests students did not necessarily reflect on how much they drank. Four possible reasons exist for this. First, students saw drinking as the norm for socialising so may not perceive it to be problematic behaviour. This finding was also reported by Penny et al. (2010). Second, many students in this study did not consider binge drinking to have any pertinent effects on their health, another finding consistent with Penny et al. (2010) who observed that many students have a nuanced perception of binge drinking. A study to assess heavy drinking students’ readiness to change their drinking behaviour found that over half were still in the pre-contemplative stage of change, indicating that

Figure 4 Illustrative quotes on managing binge drinking at the University

4a) It’s that first 80%, you know, realising this is getting a bit out of hand and it’s affecting my social life, my stress levels, and my work to make a real difference…I need someone to help me catch it. Not give me a phone number to ring once it’s all gone tits up (Club executive E)

4b) It’s still in the process but next year [we want] to have no alcohol event to go with the alcohol event (Staff B)

4c) University specifically…there might be some regulations on it but I haven’t seen them (Staff G)
many failed to acknowledge the harmful effects of their behaviour (Longstaff et al., 2014). Third, as noted by Orford et al. (2004), drinking was an effective social lubricant within new friendship circles. Finally, easy access to alcohol at the University, through the large number of alcohol-based events and venues, and low prices, was felt to influence drinking behaviour and may have contributed toward students perceiving excessive drinking to be normal behaviour. The drinking environment, including pricing and venues, has also been identified as an important predictor of drinking behaviour (Weitzman et al., 2003, Jamison and Myers, 2008). Weitzman et al (2003) suggested that addressing such environmental factors should be an area of focus at universities.

The discussions with participants in this study highlighted that the SU had concerns about student drinking, which they acted upon; although existing interventions focused on preventing adverse social consequences, as in other UK Universities (Penny and Armstrong-Hallam, 2010). Many participants in this study did not consider the strategies in place sufficient to change drinking behaviour and opportunities to manage binge drinking were discussed. The greatest support, especially from staff, was for increasing the number of alcohol-free social opportunities. In Penny and Armstrong-Hallam’s (2010) study, students raised the lack of alternatives to drinking at the University and felt more were needed.

Additional opportunities to reduce the prevalence of binge drinking at the University were also identified from this study. They included providing welfare training for students involved in organising social activities to create an inclusive social environment; creating an Alcohol Working Group to drive action and collaboration across the University and SU, and monitor progress. Finally, as peer influence appears to have a strong effect on drinking behaviour, using the student population to take ownership in raising awareness of the risks associated with binge drinking could be tried. This could be built into curricula and/or extra-curricular activities.

Few interventions to reduce student binge drinking in the UK have been published. Those that have focus upon an individual approach. This is mainly in the form of a brief intervention, which provides personalised normative feedback (PNF) on the individual’s drinking behaviour, comparing self-reported alcohol consumption to the percentage of students that drink less and against national drinking guidelines. Studies of these interventions have reported mixed results in reducing binge drinking (Bewick et al., 2013, Moreira et al., 2012). The most recent intervention study (Bewick et al., 2013), in which students were asked to monitor their alcohol intake over the 15 week study period, showed promising results at the 19-week post-intervention follow up. This suggests that a brief intervention giving PNF may be a viable option among this study’s population, challenging the perception that excessive drinking among their student peers is normal behaviour.

Interventions that have aimed to change the drinking environment, such as restricting access to and availability of alcohol, and limiting advertising to students have demonstrated some success in reducing student binge drinking and negative consequences such as crime (Weitzman and Nelson., 2004) in the US. It cannot be assumed similar positive effects would be found in the UK, given that the legal drinking age differs between the two populations. Nonetheless, if tailored to the population as the recommendations above are, they may be effective. There are no UK studies to demonstrate this and as such, necessitates further exploration.

**Study strengths and limitations**

To our knowledge this is the first study using qualitative research methods to investigate student binge drinking in the south of England. The inclusion of undergraduate students, sport club executives and university staff enabled different perspectives to be considered and recommendations based upon practicability as well as need. It confirms many findings observed in the Midlands (Penny and Armstrong-Hallam, 2010), suggesting that binge drinking may be country-wide and warrants national attention given the costs to the individual’s health and the NHS.

The study was conducted in June-July when undergraduate students had already started
leaving the University for the Summer Break, consequently recruitment was difficult and theoretical saturation was not achieved. The online questionnaire enabled more students to be reached, but precluded the exploration of their opinions. In addition, other student social organisers e.g. JCR reps, and non-drinkers were not represented in the sample.

Conclusions

The findings suggest many students at the University regularly engage in binge drinking sessions and demonstrate the need to manage this drinking pattern at the University. A number of opportunities to reduce the prevalence of binge drinking at the University were identified from this study.

References


As colleges and universities around the United States encounter financial hardships, they have felt a need to improve the quality and number of services offered on campus to attract new students. Some of these services include offering state-of-the-art wellness centers that complement and improve the overall campus experience. Universities also use these new facilities as recruiting tools (Strand et al., 2010). However, wellness is a word that has multiple definitions and encompasses multiple aspects of health and fitness.

Wellness is something that needs to be taught, encouraged, and valued within a community for it to be obtainable. This creates difficulty in creating a culture of wellness in any environment. Since Hettler originally defined wellness as multi-dimensional in 1976, multiple other wellness models have been created, complicating what people perceive to be wellness (Hettler, 1980; Ardell, 1985; Myers et al., 2000). In 2001, Corbin and Pangrazi adapted the definition of wellness as “a multi-dimensional state of being describing the existence of positive health in an individual as exemplified by quality of life and a sense of well-being” (Corbin et al., 2000). This statement best describes wellness, stating a correlation of health to quality of life and one’s personal sense of well-being.

It is estimated that only 15% to 30% of college students meet the recommended amount of physical activity (PA) that would positively affect their health (American College Health Association, 2012). Some universities are beginning to require new students to complete a course in personal wellness/fitness to assist students in meeting the required PA, and research indicates that this approach has been successful (Mack and Shaddox, 2004).

Preventable health disparities attributed to lack of PA continue to be a burden in predominantly African American communities. Preventative wellness programming has been shown to be successful for students, as well as employees, as long as it is culturally relevant, especially when working within a predominantly African American population (Izquierdo-Porrera et al., 2002).

This study established a baseline multidimensional analysis of wellness on the campus of Johnson C. Smith University that was in conjunction with the development of a new Wellness Department and opening of the HealthPlex, a facility that hosts free campus and community wellness programming, along with applied health research.

**Setting and Population**

This study was conducted on the campus of Johnson C. Smith University, in Charlotte, NC, USA. A total of 2,339 individuals who were active full-time and part-time faculty (159), staff (211), and students (1,669) were eligible for participation in this study. The overall university population demographics were: race (African American, 77.8%; Caucasian, 4.2%; Hispanic, 2.3%; Asian, .8%; Hawaiian or other Pacific Islander, .2%; two or more races, .9%; unknown race, 13.8%); average age of research participants (24), faculty (38), staff (32), and students (19). This study was able to secure 21% of the total campus population (496) with a fair representation of the underlying faculty (3.7%), staff (14.8%), and student (81.5%) population.

**Data Collection**

Participants were recruited through participation in university sponsored wellness programming and HealthPlex usage.
Participation in the research study was on a volunteer basis, no incentives or monetary funds were given for their participation. The use of a software package developed by MicroFit called HealthWizard captured and analysed three dimensions of wellness: (1) Health History, (2) Wellness Profile, and (3) Fitness Profile.

The Health History programme asked the seven questions of the Physical Activity Readiness Questionnaire (PAR-Q), which was developed by the Canadian Society for Exercise Physiology. Two supplemental questions were added, 1) Do you currently have, or getting treatment for Diabetes? 2) Do you currently have, or getting treatment for High Cholesterol? Health History was analysed by the total number of participants answering yes to the nine Health History questions as a percentage.

The Wellness Profile programme used a 46-question questionnaire that analysed the individual’s current health behaviours with a focus on exercise, nutrition, safety, tobacco use, and stress. The participant’s answers were analysed and processed by the MicroFit software package into a category scoring system: 0-100 points, with 0 being the lowest possible score and 100 meaning there is no way the participant can improve his/her score. Then each score was categorised with a rating of “room for improvement” (0-33), “fair” (34-66), or “excellent” (66-100).

The Fitness Profile software assessed 10 dimensions of fitness: body fat percentage, aerobic fitness, resting heart rate, systolic blood pressure, diastolic blood pressure, BMI, 1-minute curl-up max, 1-minute push-up max, sit and reach, and waist-to-hip ratio (WHR). The participant’s answers were analysed and processed by the MicroFit software package against national fitness standards set by the American College of Sports Medicine (ACSM). Then each score was categorized within in one of four ratings, “needs work” (0-25), “fair” (26-50), “fit” (51-75), or “excellent” (76-100). Staff, faculty, and students were scored individually as groups, and an overall campus score was developed using the combined scores of the three groups.

**University Wellness Profile Results**

Overall wellness profile results indicated that four categories placed into the “fair” rating: exercise (41), nutrition (41), safety (61), and stress (59); tobacco received a rating of “excellent” (86). The overall campus wellness score was 58 of 100, with 27.3% scoring “excellent,” 67.7% scoring “fair,” and 5% scoring “room for improvement.” The exercise score was 41 of 100, nutrition score was 41 of 100, safety score was 61 of 100, stress score was 59 of 100, tobacco score was 86 of 100 (Table 2).

The lowest scores were in exercise (41) and nutrition (41). Past research has shown numerous barriers for physical activity for men and women in the African-American community (Henderson and Ainsworth, 2003). Exercise has been identified as beneficial, but many African Americans lack the time and motivation to participate in regular physical activity. Participants cite family responsibilities and duties, and environmental, personal, and social factors as reasons for not meeting the
daily required amount of physical activity. Social factors may be the most important factors in promoting adherence to an exercise programme in African Americans as these factors were cited most often for why they do not participate in a regular physical activity (Trost et al., 1997). All of this suggested that physical activity intervention strategies need to place value on family and cultural responsibilities when dealing with an African-American population.

Not only are the barriers to exercise and physical activity great, but the perception seems to be an issue as well. African Americans have been identified for their unique perception of what is healthy. Studies have shown that significant proportions of African-American individuals are unaware of their risk for certain health conditions, such as hypertension and diabetes due to their lifestyle choices (Graham et al., 2006). Until exercise becomes a norm in the African-American community, it is believed that this number will remain one of the lowest reported wellness scores.

Eating habits in the African-American community run deep. This could explain why the nutrition score was tied for the lowest scoring wellness score as it would be difficult to encourage African Americans to eat healthier food or change their diet due to their strong cultural beliefs and social ties in regards to food. To encourage healthier eating habits, it would be best to involve teaching university food providers, employees, and students to cook soul food in healthier and less-expensive ways so they can enjoy soul food and eat healthier at the same time.

Tobacco, stress, and safety reported satisfactory scores with 89.7%, 89.3%, and 88.3%, respectively, with the majority of participants scoring “fair” or “excellent,” respectively. These results strengthen the need to focus time and resources on preventive wellness programming that will increase the amount of daily physical activity that one completes and improving nutritional habits.

University Fitness Profile Results

The overall fitness score was 48 of 100 (needs work), with 0% falling into the “excellent” category, 21.3% “fit,” 49.1% “fair,” and 29.6% in the “needs work” category. Overall results show that six of the 10 fitness dimensions reported the highest percentage of participants in the “needs works” category (body fat, aerobic fitness, BMI, curl-ups, sit and reach, and WHR), three dimensions in the “fair” category (resting heart rate, systolic blood pressure, and diastolic blood pressure), and one dimension in the “excellent” category (push-ups). Overall combined campus scores that will be watched were: average blood pressure (133/81), and BMI (28.0). Aerobic fitness (29.3ml/kg/min), body fat percentage (29.3), resting heart rate (78), WHR (.81), sit and reach (31cm), and curls-ups (31) all fell into normal standards. Push-ups (30) exceeded standards.

These results indicated that the highest percentage of participants fell into the “needs work” category in over half of the fitness dimensions (body fat, aerobic fitness, BMI, curl-ups, sit and reach, and WHR). Of these, three relate to participants carrying an unhealthy amount of excessive weight (body fat, BMI, and WHR). These data may be related to the body image perception among African Americans, which shows African Americans hold a less strict criterion of perceived body fat (Airhihenbuwa et al., 1996) and are more comfortable with “making what you’ve got work for you” (Rucker and Cash, 2006). Unfortunately, those who are overweight or obese are at a much greater risk than others for type 2 diabetes (Parker et al., 1995). It is not weight alone that increases health risks though; it is also how it is distributed along the body.

Blood pressure data gathered indicated that the combined blood pressure (BP) of participants on campus was 133/81, which is considered prehypertensive (BP 120/80 - 149/90). This coincides with the growing epidemic of hypertension (BP 140/90 and above) in African-American communities, where almost 30% have hypertension. Of those who have hypertension, only 43% have it under control (Mokdad et al., 2001). This number may be hard to change due to BP being affected greatly by one’s lifestyle; and with the indicated low wellness scores in exercise and nutrition, it shows that the campus is not currently doing what is necessary to reduce the risk of developing hypertension. This is a major concern when comparing rates by race, as African Americans have shown higher coronary
heart disease death rates in the 45-74 age groups than women and men of other races (Rodgers et al., 2012).

Aerobic fitness (VO2max) results indicate this quite clearly with VO2max scores coming in within the 30th percentile for the participants’ mean age (24) range of 20-29 (CDC, 2011). This indicates that little exercise is being done by the participants which would result in positive cardiovascular health benefits. There have been major efforts in reducing the amount of time that U.S. children and adults spend watching television, playing videos games, and using a computer. If these efforts can be paired with increases in physical activity, it could result in a substantial decrease of the onset of cardiovascular disease (Armstrong et al., 2006).

Sit-and-reach score results indicated that hamstring and low back tightness were worse than average. This can be associated with students and JCSU employees being in a seated position for prolonged periods of time, up to +6 hours a day.

**Bringing Wellness to the University**

Being able to implement free and sustainable preventive wellness programming is one step that Johnson C. Smith University can take to assist in the prevention and elimination of health disparities that predominantly affect African Americans. This research will be used to assist the HealthPlex in designing and implementing relevant preventable wellness programming that will meet needs of the participants. Such as expanding and redesigning current national, state, and county initiatives that strengthen cultural knowledge and promote a healthier lifestyle.

More value needs to be placed on the overall wellness of all members of Johnson C. Smith University by university stakeholders so to increase wellness perception within the university and within the African American community. Implementing the perfect overall wellness programme is difficult, having buy-in from the people you are trying to serve is even more difficult. Without a change in wellness perception, preventive wellness programming will never be fully successful. Success will only come from continued buy-in and the ability to seek and accept feedback and being able to adjust wellness programming needs accordingly.

Investment in preventative wellness programming can assist the 50 percent of African Americans who suffer from a chronic disease that can be easily prevented simply from living a healthy lifestyle. New programming and initiatives can be costly, but a true commitment to wellness prevention most show a commitment to the one’s being served and offers these programmes at no charge, exempting these benefits from deductibles and other cost-sharing requirements. This will ensure that all who seek help will have access to relevant services that will assist in preventing illness and disease before they require more costly treatment.

The fact that these findings were closely related to the national health reports of African Americans, with the reinforcement of the review of literature, should be a strong enough reason to continue to explore the health and wellness need and desires of African Americans. This study will, hopefully, bring more attention to the need to offer free-to-low cost preventable wellness programming that will increase the understanding and desire of African Americans to live healthy lifestyles, thus eliminating preventable health disparities within their communities.

References


Table 1. Health History Question Results

<table>
<thead>
<tr>
<th>Health History Question</th>
<th>Percentage of Respondents Answering “Yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?</td>
<td>0.6%</td>
</tr>
<tr>
<td>Do you feel pain in your chest when you do physical activity?</td>
<td>5.4%</td>
</tr>
<tr>
<td>In the past month, have you had chest pain when you were not doing physical activity?</td>
<td>4.8%</td>
</tr>
<tr>
<td>Do you lose balance because of dizziness or do you ever lose consciousness?</td>
<td>4.2%</td>
</tr>
<tr>
<td>Do you have a bone or joint problem that could be made worse by a change in your physical activity?</td>
<td>5.6%</td>
</tr>
<tr>
<td>Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</td>
<td>5.4%</td>
</tr>
<tr>
<td>Do you know of any other reason why you should not do physical activity?</td>
<td>1.0%</td>
</tr>
<tr>
<td>Do you currently have, or getting treatment for Diabetes?</td>
<td>1.6%</td>
</tr>
<tr>
<td>Do you currently have, or getting treatment for High Cholesterol?</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Table 2. Campus Wellness Profile Score

<table>
<thead>
<tr>
<th>Wellness Category</th>
<th>Score (0-100 scale)</th>
<th>Excellent</th>
<th>Fair</th>
<th>Room for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise</td>
<td>41</td>
<td>27.3%</td>
<td>67.7%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>41</td>
<td>32.2%</td>
<td>13.5%</td>
<td>54.2%</td>
</tr>
<tr>
<td>Safety</td>
<td>61</td>
<td>7.9%</td>
<td>62.4%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Stress</td>
<td>59</td>
<td>51.1%</td>
<td>38.2%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>86</td>
<td>36.2%</td>
<td>52.1%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Overall Wellness</td>
<td>58</td>
<td>82.0%</td>
<td>7.7%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>
Young People into 2014, is a "unique contemporary archive" of young people from the Schools Health Education Unit (SHEU). Each year, since 1977, SHEU carry out healthy lifestyle surveys with young people and, in 2013, this involved over 58,000 youngsters. This report contains over 100 health-related behaviour questions and answers from over 30,000 pupils between the ages of 10 and 15. They tell us about what they do at home, at school, and with their friends. The data have been collected from primary and secondary schools across England. The report is the 28th in the series.

What's new and different in Young People into 2014?

Some of the differences are not new – they are continuations of trends that we have seen going on for some time.

Dr David Regis, Research Manager of the Schools Health Education Unit, says,

“We saw a peak of young people's use of tobacco, alcohol and cannabis in the mid-1990s, and since then there has been a general decline in use. We have seen a shift too in their perceptions of the dangers of cannabis. Whether they have been deterred from experimentation by good drugs education or have been attracted to other pastimes – perhaps online – we cannot tell from these figures, but it's good news regardless.”

“We have always been concerned about the emotional wellbeing of young people. A while ago we took stock of young people's emotional wellbeing as seen in our figures (SHEU, 2005). At the time, we were fairly sanguine, as we thought that, while different worries came and went, young people's self-esteem was holding up well and even increasing. We suspect that this is no longer the case: the data series shows a peak in the percentage of Year 10 females scoring in the highest bracket of self-esteem scores in 2007, but the figures in that group have since declined.”

Percentage of young people scoring in highest bracket of self-esteem scores, 1985-2013, SHEU aggregate figures, by age and sex
Angela Balding, Survey Manager at the Schools Health Education Unit, says,

“The rising trend of self-esteem from 1997-2007 stopped in 2008, and the figures we are seeing for high self-esteem in 2013 are generally lower now than 2007. The 2008 date coincides with the economic recession, so that’s a plausible explanation of what we see – but we are also aware of new pressures about being online and of online bullying. We can also see among the pupils with low self-esteem that they are much more likely than their peers to have experienced bullying at or near school in the last year. We don’t know if that’s because bullying causes a drop in self-esteem, or if pupils with low self-esteem are more likely to be picked on, or both.”

“We have also shown in this year’s publication more of the types of analysis we are often asked to do by local authorities, that is, showing links between behaviours and links between behaviours and demographic characteristics. We have been able to show:

- Year 10 pupils who have free school meals are less likely to want to stay in full-time education after Year 11 than are their peers
- Year 10 males who have a mixed ethnic heritage are more likely to use substances than are their peers
- Year 10 pupils who are young carers are less likely to have seen a dentist in the last 6 months than are their peers
- Year 10 pupils who are lesbian, gay or bisexual are more likely to report having been bullied at or near school in the last year than are their peers (and are more likely to report using substances)
- Year 10 pupils who are religious are less likely to have tried smoking than are their peers
- Year 10 pupils who have a disability are less likely to have tried smoking than are their peers (but are more likely to report having been bullied at or near school in the last year)

We can see these behaviours, therefore, not as isolated items in a questionnaire, but as parts of young people's lives embedded in a social and cultural matrix.”

Dr Regis says,

“The landscape in which we work continues to evolve and make life more interesting. The synergy between public health and education within local authorities is tangible and encouraging. We are being pushed to develop our services in different directions and to explore new topics.

As regards the aggregate data sets from which we publish this series of reports, they have become more complex and busy. We have seen some items dropped from the report, as too few clients chose those questions for their surveys, while a few items have been added to the reports. There are new items for this 2014 report about personal background; e-safety; second-hand smoke; perceptions of drugs; barriers to exercise; responses to problems and sexuality and we have had a brief look at religion and belief.”

“For these reasons, we have taken another look at the representativeness of the data sets from which we derive our figures [see charts below]. We compared the profile of the schools in our data sets with what we can see in the country as a whole, and we were pleasantly surprised by the similarity. This confirms what we concluded a decade ago through a similar study: that the SHEU data sets are reasonably well-matched to the national population of schools.”
Young People into 2014 report

Summary

Chapter 1 - Food choices & weight control
- In the sample, 62% of 14-15 year old females, 53% of 12-13 year old females and 33% of 10-11 year old females 'would like to lose weight'. This compares with 27% of 14-15 year old males, 32% of 12-13 year old males and 27% of 10-11 year old males who 'would like to lose weight'
- 14% of Year 10 females have 'nothing at all to eat or drink for breakfast this morning' and 20% had nothing for lunch on the previous day
- Less fresh fruit and vegetables are eaten as pupils get older and up to 55% report eating 1-3 portions of fruit and vegetables. 16% of 14-15 yr. olds and 27% of 10-11 yr. olds report eating 5 or more portions of fruit and vegetables 'yesterday'
- Up to 78% of 12-15 year olds reported drinking less than 1 litre of water

Chapter 2 - Doctor & Dentist
- Up to 26% of the 12-15 year old females, reported feeling 'quite uneasy' or 'very uneasy' on their last visit to the doctor

Chapter 3 - Health & Safety
- Most 12-15 year olds report sleeping 8 or more hours 'last night'. There is a strong relationship between sleep patterns and a number of variables. For example, for 14-15 year old females, the more sleep they get they are less likely to: want to lose weight; worry 'a lot' and feel afraid about going to school due to bullying (see table below)

<table>
<thead>
<tr>
<th>Hours of sleep</th>
<th>Would like to lose weight</th>
<th>Worry 'A lot'</th>
<th>Never afraid of going to school because of bullying</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 3 hrs</td>
<td>59%</td>
<td>81%</td>
<td>50%</td>
</tr>
<tr>
<td>4-5 hrs</td>
<td>71%</td>
<td>83%</td>
<td>60%</td>
</tr>
<tr>
<td>6-7 hrs</td>
<td>64%</td>
<td>68%</td>
<td>85%</td>
</tr>
<tr>
<td>8-10 hrs</td>
<td>57%</td>
<td>51%</td>
<td>82%</td>
</tr>
</tbody>
</table>

- Up to 24% of young people say that safety after dark in their area is 'poor' or 'very poor'
- Up to 85% say they have been advised how to stay safe while chatting online
- Up to 12% have been a victim of violence in their area
- 32% of 10-11 yr. old females feel afraid (at least 'sometimes') of going to school because of bullying (see chart below)

Chapter 4 - Family & Home
- As they get older, fewer pupils report living with both parents (see chart below)

- Up to 43% of the 10-15 year olds walk, at least some of the way, to school
- More females than males did homework on the evening before the survey, and they tended to spend longer at it. 30% of the 14-15 year old males did no homework at all 'yesterday'
- Up to 84% of males played computer games after school 'yesterday'

Chapter 5 - Legal & Illegal Drugs
- Since the mid-1990s there has been a general decline in the percentage of 14-15 year olds who smoke regularly. Around
97% of 10-11 year olds say they have never smoked. This figure drops to 66% (males) and 60% (females) by the time they are 14-15 years old. Around 35% of 12-15 year olds live in a 'smoky' home. 22% of 14-15 year old girls reported smoking and 27% reported drinking alcohol 'in the last 7 days'.

- Around 50% of the 14-15 year olds are 'fairly sure' or 'certain' that they know a drug user. Up to 9% of 14-15 year olds have mixed drugs and alcohol 'on the same occasion'.
- Up to 14% of 14-15 year olds report taking cannabis and, as they get older, fewer pupils think that cannabis is 'always unsafe'.

Chapter 6 - Exercise & Sport

- Over 92% of the sample of 10-15 year olds report exercising at least on one day 'last week'. At least 73% of all males and 74% of 10-11 year old females report exercising vigorously on 3 or more days 'last week'.
- 66% of 10-11 year old females think they are 'fit' or 'very fit'. This falls to 25% by the time they reach 14-15 years of age (chart below).

Chapter 7 - Social & Personal

- 'School-work problems' are a worry for 14-15 year old females and 'the way you look' remains the main worry for 12-15 year old females.
- 67% of 14-15 year old females, compared with 52% of 14-15 year old males, want to continue with full-time education after Year 11.
- Statements from the 'Every Child Matters' section show a marked difference between the positive responses from primary and secondary pupils e.g. responses to, 'The school helps me work as part of a team' drop from around 63% (10-11 year-olds) to around 36% (14-15 year-olds).
- Younger (12-13 year-old) males continue to be the most satisfied group when 12-15 year olds are asked about how they feel about their life 'at the moment'.

Chapter 8 - Some responses from primary-age children that are not contained in Chapters 1-7

- Up to 22% of 10-11 year olds report being picked on for 'the way they look'.
- 28% of 10-11 year olds report being approached by an adult who scared them or made them upset.

Since 1991, there is a downward trend for some pupils reporting they are 'fit/very fit'.

Young People into 2014 is available to purchase [£25 wire bound incl. p&p] via this link …
http://sheu.org.uk/yp14