Chapter I

Introduction
INTRODUCTION

The study of health behaviours is based upon two assumptions: that in industrialized countries a substantial proportion of the mortality from the leading causes of death is due to a particular behaviour patterns, and that these behaviour patterns are modifiable (Stroebe and Stroebe, 1995). It is increasingly recognized that individuals can make major contributions to their own health and well-being through the adoption of particular health enhancing behaviours (e.g. exercise) and the avoidance of other health compromising behaviours (e.g. smoking). The identification of the factors that underlie such ‘health behaviours’ has become the focus of a great deal of research in psychology and other health-related disciplines in recent years (e.g. Hockbaum and Lorig, 1992; McLeroy et al, 1993; Adler and Matthews, 1994). This research has been motivated by two main factors: first, a desire to design interventions to enhance healthy eating behaviours and so produce improvements in individuals and populations health; second, a desire to gain a more general understanding of the reasons why individuals perform a variety of these behaviours. Health behaviours have been defined as ‘Any activity undertaken by a person believing themselves to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage’ (Kasl and Cobb, 1966). There are several limitations to this conception, including the omission of lay or self-defined health behaviours and the exclusion of activities carried out by people with recognised illnesses that are directed at self-management, delaying disease progression or improving general well-being.

A variety of factors account for individual differences in the propensity to undertake health behaviours, including demographic factors, social factors, emotional factors, perceived symptoms, factors relating to access to medical care, personality factors and cognitive factors (Rosenstock, 1974; Taylor, 1991; Adler & Matthews, 1994). Demographic variables show reliable associations with the performance of health behaviours. For example, age appears to show a curvilinear relationship with many health behaviours, with high incidences of many health-risking behaviours such as smoking in young adults and much lower incidences in children and older adults (Blaxter, 1990). Health behaviour also varies by gender, with females being generally
less likely to smoke, consume large amounts of alcohol and engage in regular exercise, but more likely to monitor their diet, take vitamins and engage in dental care (Waldron, 1988).

Differences by socioeconomic status and ethnic status are also apparent for behaviours such as diet, exercise, alcohol consumption and smoking (e.g. Blaxter, 1990). Generally, younger, wealthier, better educated individuals under low levels of stress with high levels of social support are more likely to practice health-enhancing behaviours. Higher levels of stress and/or fewer resources are associated with health compromising behaviours such as smoking and alcohol abuse (Taylor, 1991; Adler & Matthews, 1994). Social factors, such as parental models, seem to be important in instilling health behaviours early in life. Peer influences are also important, for example in the initiation of smoking (e.g. McNeil et al, 1988). Values of a culture also appear to be influential, for instance in determining the number of women exercising in a particular culture (e.g. Wardle & Steptoe, 1991). Emotional factors play an important role in the practice of some health habits. For example, over-eating is linked to stress in some obese people. Self-esteem also appears to be an important influence in the practice of health behaviours by some. Personality factors have been either positively (e.g. optimism) or negatively (e.g. negative affectivity) associated with the practice of health behaviours (Adler and Matthews, 1994; Steptoe et al, 1994).

Cognitive factors also determine whether or not an individual practises health behaviours. For example, knowledge about behaviour health links (or risk awareness) is an essential factor in an informed choice concerning a healthy lifestyle. A variety of cognitive factors are studied. These factors include perceptions of health risk, potential efficacy of behaviours in influencing this risk, perceived social pressures to perform the behaviour and control over performance of the behaviour. Social cognition is concerned with how individuals make sense of social situations. The approach focuses on individual cognitions or thoughts as processes which intervene between observable stimuli and responses in specific real world situations (Fiske and Taylor, 1991).

Health promotion is a comprehensive and ambitious activity that entails a preventive approach to all factors that influence people’s quality of life (Perry & Jessor, 1985).
The World Health Organisation (WHO, 1986) defines health comprehensively and positively as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Correspondingly, to be effective, health promotion efforts ought to be comprehensive. That is, to the extent possible, they should consider historical, ecological, cultural, political, economic, social, psychological, and biological factors, integrating aspects of public health, education, psychology, sociology, nursing, and medicine in an attempt to facilitate the optimal development and well-being of all persons. Healthy development can be promoted by structural and political initiatives, as well as by direct assistance to individuals and families (Feagans, 1992; Lerner, et al., 1993).

Health is expressly understood as an essential component of daily life, with major emphasis being placed on the importance of personal and social resources. Health promotion is described as a process that enables individuals to acquire a greater degree of autonomy and responsibility for their own health. The aim of health promotion is to influence the social and natural environment with respect to health and at the same time to develop individual competence. To achieve a state of health and well-being, it is essential that individuals and groups be able to fulfil their needs, be aware of and achieve their hopes and wishes, and have an influence on their environments (Compas, 1993; Hurrelmann & Lasser, 1993; Millstein et al., 1993). From a developmental perspective, health promotion should involve attempts to support, alter, or redirect developmental processes that are already in motion. That is, the goal is not only to alter current attitudes and behaviours, but also to have an enduring impact on developmental trajectories (Cairns & Cairns, 1994; Vondracek et al., 1986). The term developmental intervention has been used to describe such efforts, which may target any aspect of individuals (e.g., biochemical, cognitive, social) or their environments, and may take place at any point, or across several points, in the life span (Fisher et al., 1993; Vondracek et al., 1986).

Eating Behaviour

Healthy eating is believed to play a crucial role in the prevention of obesity, cardiovascular (Richardson, 2000) disease, cancer, diabetes, and osteoporosis (McKeith, 2004; Renner, Hermes, & Stracke, 1998; Steinmetz & Potter, 1996). Although there are many efforts to promote healthy eating in individuals, studies suggest that
individuals, especially adolescents, fail to adhere to healthy eating practice (Johnson & Hackett, 1977; Reynolds et al., 1999; Sjoberg et al., 2003). These behaviours are of concern because eating behaviour established in adolescence is likely to affect not only the health of an adolescent but also health and well-being in adulthood (Videon & Manning, 2003). Many studies report a relatively weak correlation between nutrition knowledge and dietary behaviours in adolescents. Some studies even revealed no relationship between adolescent knowledge about healthy diets and their actual behaviours (Baranowski, Cullen, & Baranowski, 1999). Thus, other alternative influences must account for adolescent eating behaviours.

Influences on adolescent eating behaviours have been explored and categorized into many different perspectives (Ogden, 2003). Altogether, these influences may be categorized in two broad categories, which are individual and environmental influences. Individual influences consist of individual cognitions and characteristics that influence eating behaviour such as attitude, beliefs, self-efficacy, meal pattern, and lifestyle (Story, Neumark-Sztainer, & French, 2002). Environmental influences are represented by the adolescent’s social environment such as family and peers as well as physical environment such as availability of such foods (Berg et al., 2002; Videon & Manning, 2003). Of all these influences, investigators play attention to the cognitive factors partly because they have been shown to affect behaviour (Conner & Norman, 1998) and partly because they are influences which are potentially modifiable (Povey et al., 2000).

Poor eating habits are an important public health issue that has large health and economic implications. Poor nutrition and obesity are among the most important health issues facing society today, not only in terms of health, but also health care expenses (Goel, 2006, Rashad & Grossman, 2004). There are a variety of predictors of obesity including genetics, physical activity, and food consumption (Goel, 2006). There are other outcomes of food choice and nutrition that also have an independent effect on health including some types of cancer, cardiovascular disease, and diabetes (Nicklas et al., 2001). For these reasons, food selection is an important consumer behaviour with many long-term consequences to the individual in the form of health and longevity and to society in the form of health costs.
Research has shown that the most important factors predicting food selection among adults are: taste, cost, nutrition, convenience, pleasure, and weight control (Glanz et al., 1998). Many studies have shown that people often establish these tastes and habits while they are relatively young (Birch, 1999). Evidence suggests early establishment of habits and preferences occurs for a variety of behaviours including media use (Basil, 1990) and music listening (Holbrook & Schindler, 1994), as well as food choice (Birch, 1999). Therefore it is advisable to begin establishing good eating habits when people are as young as possible. Importantly, however, for the very young many food decisions are controlled by parents and preschools (Nicklas et al., 2001). Therefore, food choice for the youngest age groups may be constrained by a number of factors.

An especially important time of life for food choice is when people step out independently for the first time and begin to make all of their own food decisions. For many people, this is the transition to college life. The transition to college or university is a critical period for young adults, who are often facing their first opportunity to make their own food decisions (Baker, 1991; Marquis, 2005) and this could have a negative impact on students' eating behaviours (Marquis, 2005). According to Blinkhorn & Palmer (2001) it is considered to be important to educate young people about eating habits to ensure that they have the knowledge to deal with health choices in order to maximize their quality of life. Both underweight and overweight feature in the top ten risks in terms of the global burden of diseases (World Health Organisation, 2002). Adolescence is a period of time in which children are prone to a higher prevalence of risk taking behaviour such as overeating and under eating. Overeating and under eating can be a displacement for other problems such as low self-concept, interpersonal problems, and an acute sense of shame and doubt (Segal, 2001).

There has been a dramatic increase in the number of adolescents with unhealthy eating habits over the past twenty years. The prevalence of unhealthy eating habits has increased in all socio economic classes in the last two decades and as a result, there is growing recognition on the part of professionals, parents and educators for an intervention programme to deal with unhealthy eating habits (Adolfsson et al., 2002). Over the last ten years there has been an increase in the number of adolescents who are preoccupied with weight and therefore populations can be at great risk for developing
unhealthy eating habits (Collins, 1991; Graham, 1998; Hill, Oliver & Rogers, 1992). As a consequence of unhealthy eating habits we are seeing very significant increases in chronic disease morbidity in many countries at an earlier age (Catford, 2003; Hartley, 1998).

Several models of individual health behaviours that emphasize social cognitive factors were developed to explain and predict an individual’s health behaviour, such as the Social Cognitive Theory (SCT; Bandura, 1986), Health Beliefs Model (HBM; Becker & Rokenstock, 1984), and the Theory of Reasoned Action (TRA; Fishbein & Ajzen, 1975) and the Theory of Planned Behaviour (TPB; Ajzen, 1991). Of all these theories, the Theory of Reasoned Action and the Theory of Planned Behaviour have had a major influence on both research and practice in health behaviour and health education.

The Theory of Reasoned Action posits that the performance of a particular behaviour is determined by intention to perform or not perform it. Behavioural intention is in turn influenced by two factors. First, the individual’s attitude towards the behaviour, which refers to the extent to which the individual has a favourable or unfavourable evaluation of the behaviour. Second, the subjective norm or perceived social pressure to perform or not perform the behaviour. The Theory of Reasoned Action was based on the assumption that all relevant social behaviours are under volitional control. This assumption in challenged with behaviours which are subject to outside control in terms of resources, cooperation, and skills (Ajzen, 1991). Thus, Ajzen included the concept of perceived behavioural control (the degree to which the behaviour is perceived to be under the control of the individual) in the Theory of Reasoned Action and renamed it to be the Theory of Planned Behaviour. The Theory of Reasoned Action and the Theory of Planned Behaviour have been used to predict behavioural intention related to performance of eating behaviour with marked success.
**Theory of Planned Behaviour**

The Theory of Planned Behaviour (Ajzen, 1991) is an extension of Fishbein and Ajzen’s Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), which was developed to explore human behaviours. The extended model was developed after the results from empirical studies showed a limited success of the theory to only explain behaviours which are under a volitional control (Brown, 1999). According to the Theory of Planned Behaviour, the most important determinant of behaviour is an individual’s intention to perform or not perform behaviour. Behavioural intention is in turn a function of three factors: attitudes, subjective norms, and perceived behavioural control (see Figure 1.1).

![Figure 1.1 The schematic representation of the Theory of Planned Behaviour (Ajzen, 1991)](image)

The ultimate goals of the Theory of Planned Behaviour are to predict and understand a human’s behaviours, which are congruent with the ultimate goals of this study. This study focuses on determining the factors that influence healthy eating behaviour in early adolescents. According to the Theory of Planned behaviour, perceived
behavioural control, together with intentions, can be used directly to predict behaviour achievement. The relative importance of intentions and perceived behavioural control in the prediction of behaviour is expected to vary across situations and across different behaviours. When the behaviour or situation provides individuals with complete control over behaviour performance, intentions alone should be sufficient to predict behaviour. The addition of perceived behavioural control should be of more benefit when an individual’s volitional control over the behaviours declines (Ajzen, 1991). However, this study focuses on eating behaviour, which Armitage and Conner (2001) suggest is a relatively volitional behaviour. Results from many studies emphasize eating behaviours show a lack of evidence for perceived behavioural control influencing eating behaviour, while intention to perform showed quite good levels of prediction (Gummeson et al., 1997; Kassem et al., 2003). Further, most adolescents reported having their diets without adults’ supervision (Pongkiatchai, 1999).

**EATING BEHAVIOUR OF COLLEGE STUDENTS**

It is important that young people’s health is considered in its broadest sense, as encompassing physical, social and emotional wellbeing; and that, in accordance with the WHO perspective, health is viewed as a resource for everyday living, not just the absence of disease. Research into youth’s health and health behaviour and the factors that influence them is essential for the development of effective health education and health promotion policy, programmes and practice targeted at young people. Thus, research into children’s health needs to consider the positive aspects of health, as well as risk factors for future ill health and disease. Many of the behaviours that comprise young people’s lifestyles may directly or indirectly impinge on their health in the short or long term; consequently, a wide range of behavioural variables should be measured. Positive or health promoting behaviour needs to be studied, as well as health-damaging or risk behaviour. Certain behaviour is initiated in the adolescent years, while some patterns of behaviour, such as eating patterns, become established in earlier childhood. Taking social as opposed to a purely biomedical research perspective means studying the social, environmental and psychological influences or determinants of child and adolescent health and health behaviour. Thus family, school and peer settings and relationships need to be explored, as does the socioeconomic environment in which young people grow up,
if we are to understand fully the patterns of health and health behaviour found in the adolescent population.

Eating a healthy diet and being physically active are essential to leading a healthy and long-lasting life. According to the United States Department of Health and Human Services (US DHHS), engaging in moderate physical activity can significantly reduce the risk of developing or dying from chronic diseases such as heart disease, diabetes, colon cancer, or high blood pressure (US DHHS, 2004). Studies have indicated that college students have poor nutrition habits and often exhibit at-risk weight control behaviours. College students tend to engage in a number of unhealthy eating behaviours, including extreme dieting, skipping meals, and high intake of fast foods, low intake of fruits and vegetables, and minimal consumption of dairy products (Cotunga and Vickery, 1994; Douglas and Collins, 1997; Huang, et al., 2003; Matvienko, Lewis, and Schafer, 2001). Furthermore, when young adults begin college, the new environment may place them at increased risk for developing unhealthy eating habits and adopting a more sedentary lifestyle. Since beginning college is a period when students begin to manage their own lives and adopt and solidify their health-related habits, it is important to investigate factors associated with activities such as being physically active and choosing to consume a diet rich in fruits and vegetables. In order to help college students adopt more proactive approaches to health and lead longer and healthier lives, valid interventions to improve their lifestyles must be identified and implemented. For effective models of intervention to be formulated, groundwork on how eating a healthy diet and physical activity affect an individual must be laid. Many studies focus on topics that can be applied to developing health interventions. Some researchers are studying how knowledge of diet and physical activity may affect people’s corresponding health behaviours. For example, nutritional knowledge has been positively correlated with healthy eating (Wardle, Parmenter, and Waller, 2000), and knowledge regarding physical activity has been positively correlated to being more active (Rimal, 2001).

Determinants of Eating Behaviour

Previous studies have shown a link between demographic and psychographic characteristics with dietary behaviour of college students. Driskell et al. (2005) revealed
few differences among lower and upper level students in terms of their dietary habits, suggesting that habits established in the first year or two likely carry forward into later college years. However, where a student lives seems to affect his or her dietary habits and diet-related health (Brevard & Ricketts, 1996). Students living off-campus reported a higher percentage of energy from protein. Similarly, serum triglyceride level and the ratio of total cholesterol to high-density lipoprotein were also higher among students living off-campus. The authors conclude that students living off campus are choosing different foods than those living on campus.

Research studies have shown the relation of Gender with eating behaviours. Female college students tend to eat more fatty foods than male students, although their fruit and vegetable consumption tends to remain similar (Racette et al., 2005). As discussed earlier, according to Brevard & Ricketts (1996), residence on or off campus made a difference, but it also interacted with gender. Higher energy from protein was more prevalent among men living off campus than on campus. For women, higher serum triglyceride and ratio of total cholesterol to high-density lipoprotein was found among those who lived off campus. Horacek & Betts (1998) clustered male and female college students by dietary intake differences. Four clusters were found: students influenced by internal (hunger and taste) and external cues (friends and media), by budget, by health, and neither of the factors. Males tended to be equally represented in all the four clusters with a somewhat higher percentage in the cues group, while female students tended to cluster in the cues group (55%) followed by health factors (28%). In a study by Mooney & Walbourn (2001), females avoided certain foods for their concern for weight, health and ethical reasons more significantly than males. Marquis (2005) similarly reported that females were more significantly motivated by convenience, pleasure, price, and weight concerns than male students. We can thus conclude that the dietary intake of male and female college students is influenced by different factors.

Motives influencing eating behaviours among college students have been studied as well. House, Su, & Levy-Milne (2006) investigated what benefits college students believed result from a healthy diet. In this study, students at a Canadian university reported healthy eating to be helpful in providing a healthy appearance (in terms of weight, skin, physique, and so forth), providing positive feelings, and preventing disease.
Although the results in this study were based on a focus group finding with 15 students, there are nonetheless similarities with studies conducted among general adults (Steptoe, Pollard, & Wardle, 1995). Horacek & Betts (1998) found that taste, time sufficiency, convenience, and budget influenced students' eating habits in that order. These seem to act more as barriers to healthy eating as revealed from the focus group (House et al., 2006). One could assume that these barriers may be more influential than benefits given the prevalence of eating habits among college students.

Other factors associated with poor eating habits among college students include a higher perception of stress (Cartwright et al., 2003), and low self-esteem (Huntsinger & Luecken, 2004). Previous studies have also reported a low level of nutrition knowledge (Van den Reek & Keith, 1984). Lack of indepth nutrition knowledge has been attributed to reliance on sources that provide inadequate information on nutrition (Thomsen, Terry, & Amos, 1987). There is an awareness that low self-concept is associated with health compromising behaviours such as unhealthy eating habits but very little longitudinal research addressing this issue has been done (McGee & Williams 2000). By enhancing self-concept it may be possible to reduce health compromising behaviour such as unhealthy eating habits.

**PSYCHOEDUCATION**

According to Hatfield as cited in Allen (2001), education is designed to “develop long-term, organized bodies of knowledge and generic problem-solving skills that will help the learner solve personal problems, both in the present and in the future”. Psychoeducation is the “process of teaching clients with mental illness and their family members about the nature of the illness, including its etiology, progression, consequences, prognosis, treatment and alternatives (Barker, 2003). Psychoeducation’s goal is to offer education and therapeutic strategies to improve the quality of life for the family while decreasing the possibility of relapse for the patient (Solomon, 1996). It also has been described as a “systematic didactic-psychotherapeutic intervention, designed to inform patients and their relatives about the disorder and to promote coping (Lincoln, Wilhelm, & Nestoriuc, 2007). By strengthening the coping skills, communication and problem solving abilities of the family, the well-being and adaptability of the individual
and family members are expected to improve. Even with limited empirical evidence suggesting the importance of psycho-education, practical application and experience has proven its effectiveness (Creamer & Forbes, 2004; Landsverk & Kane, 1998).

Psycho-education can be used to normalize a traumatic experience or memory (Glodich & Allen, 1998; Psycho-education, 2006). It can be in written form or through verbal communications to aid in the therapeutic approach. Psycho-education is education used in therapy and includes discussion and application for the edification of the client’s knowledge regarding the diagnosis, treatment options and techniques for coping (Psycho-education, 2006; W. P Hornung et al, 1996). It is effective in removing myths associated with the diagnosis, providing statistical data, and in describing the symptomology of the diagnosis and also can be effective in reframing of events.

**Early intervention**

Early intervention is defined as the immediate action following onset or diagnosis to ameliorate the effects of a disability; action taken to prevent a possible disabling condition (CIRRIE, 2008). Early intervention is important because it increases the individual’s knowledge on the diagnosis or illness (Fung & Frye, 1998), which can decrease or alleviate stress (Creamer & Forbes, 2004) and provides information regarding specific treatment models pertinent to their condition (Pratt et al., 2005). Early intervention is useful to support newly acquired knowledge, coping mechanism and skills (Fung & Frye, 1998).

According to Edwards & McGorry (2002), the rationale for early intervention is early detection, decreased delays of effective treatment and possible delay of onset of the illness. Early intervention, “involves identification of warning signs for individuals at risk for mental health problems and intervening early against factors that put them at further risk for developing mental disorders” (Doyle, 2005) in order to reduce long term harm or worsening symptoms (HHD, 2008; Institute of Psychiatry, 2006). Early intervention also can “dramatically improve...immediate and long term health outcomes (Paterson, Jones, Dagg, Scanlon & Raphael, 2001).
GROUP THERAPY AND PSYCHO-EDUCATION

Group therapy is a treatment method used with groups of people who have experienced similar symptoms related to an illness or diagnoses. Group therapy is usually recommended after the treatment of primary symptoms through individual counselling and is widely utilized because it is effective while being cost efficient. The use of psycho-education in groups is important to ensure that the client has a better understanding of symptoms, triggers and coping strategies.

Group therapy can be designed with different rules, ideas and goals, but all models of group therapy have some similar qualities and expectations. Group therapy allows the person to connect with other individuals sharing similar experiences, which validates and normalizes his/her feelings, and fosters a sense of commonality. Most groups are homogeneous; for example they all share a common trauma (Foy, Schnurr, Weiss, Wattenberg, Glynn, Marmar & Gusman, 2001). It allows that person to have a safe haven where he/she can begin to rebuild and regain trust (Allen, 2001; Foy et al., 2001).

Group therapy works under the premise that members take a non-judgmental approach of other members, are supportive in nature, and share collective responsibility and healing for the common experience (Williams, 1987). This fosters “a psychologically safe, respectable therapeutic environment which permits members to address issues of trust” (Foy et al., 2001). The success of a group is dependent upon the realized improvement of the person’s quality of life, symptoms and renewed sense of trust. By incorporating psycho-education into the group setting, it allows the group members to add personal meaning to the concepts and symptomology of the disorder, reinforcing the subject matter with personal accounts (Allen, 2001).

There are several specific types of group therapy models such as psychodynamic group therapy, cognitive behaviour approaches and supportive group therapies. Psychodynamic and cognitive behavioural group therapy focuses on the effects of the traumatic event in daily life, cognitive functioning and behaviours. This type of therapy can involve vicarious re-traumatization and memories for the client. Supportive group therapy provides support for current everyday issues and it is focused on the here-and-now.
Healthy Eating Behaviour

Healthy eating behaviour is a pattern or style of eating behaviour that participants practice in order to consume a proper amount of specific foods or nutrients to maintain or promote their health. In this study, healthy eating behaviour encompasses having balanced or varied diets, consuming fewer amounts of fat, sugar, and salt, and consuming an appropriate amount of food in five major food groups.

Increase of Eating related problems among youths

Eating behaviour is modifiable health behaviour. Food choices, like many other health behaviours, can be affected by a number of factors. The prevalence of increasing rates of obesity, which is a result of excessive caloric intake in relation to caloric output, is evident across all populations and is raising concern. Previous research has shown the most important factors predicting food selection among adults are: taste, cost, nutrition, convenience, pleasure, and weight control (Glanz et al., 1998). Many previous studies have shown people often establish taste preferences and eating habits while they are relatively young (Birch, 1999; Drewnowski & Hann, 1999). However, the most important time of life for food selection choice is when they are college students (Deshpande & Basil, 2009). When individuals leave the family home to attend college is a critical period for young adults, in which they are given the opportunity to make their own food decisions and can have a negative impact on students’ eating behaviours (Marquis, 2005).

Numerous studies have reported college students often have poor eating habits. Students tend to eat fewer fruits and vegetables on a daily basis and report high intake of high-fat, high-calorie foods (Driskell, Kim, & Goebel, 2005; Racette et al., 2005). The change to college life often deteriorates dietary habits among students (Grace, 1997) which could contribute to weight problems especially during the first year of college and continue during life of later years (Racette et al., 2005). The eating behaviours college students choose may not always be based on scientific evidence. In fact, eating behaviours may be based on advice from friends and family, television and the media, from the variety of diet books available, or from the latest trendy diets. Currently, many books which are related to diet and Internet sources are based around a similar idea that all high-calorie food needs to be eliminated or customized in order to lose weight.
There are very few studies to support the safety of these diets, or to evaluate the impact. We need to study more about college students’ eating behaviour or important factors to evaluate eating behaviours (Wedig & Nock, 2010).

College students exhibit a distinct decline in nutritional priorities, and poor eating habits often make something worse during this time. Most student diets are compose of fast-food that are high in fat and sodium content (Baskin, Ard, Franklin, & Allison, 2005; General, 2001). In 2006 U.S. Department of Education reported in Healthy People 2010 specifically identified post-secondary educational institutions as settings where young adults (aged 18–24) should be targeted for exercise promotion. One aspect of promoting a healthy lifestyle within educational institutions is the presence of required health and physical education courses (Pearman et al., 1997). Although some studies suggest that university-sponsored physical activity and health classes have the potential to positively affect the attitudes and behaviours of the students, others have been uncertain (Cardinal, Jacques, & Levy, 2002). In the meantime, knowledge about healthy foods may influence people to develop a healthy diet. Few studies have studied the eating behaviour of college students (Galloway, Farrow, & Martz, 2009; Hekler, Gardner, & Robinson, 2010; Le Grange, Telch, & Tibbs, 1998; Li et al., 2009; Rucker III & Cash, 1992). This study will assess college students’ eating behaviour related to psychosocial predictors of healthy eating. An enhanced understanding of factors that influence healthy food knowledge, eating behaviours, and predictors of healthy eating will enable university foodservice or health-care providers to construct more effective interventions or management for improving their health in this population. This research has the potential to benefit the eating behaviour of university students which merits future consideration.

Need for profiling young adults with Psycho-education

Adolescence is a particularly important phase of life for developmental intervention for several reasons. In the domain of physical health, the primary causes of mortality and morbidity during adolescence, as in adulthood, are related to preventable social, environmental, and behavioural risk factors (Crockett, Irwin & Millstein, 1986, 1992). Many health problems of adulthood have their origin in behavioural patterns that are formed during adolescence such as smoking, exercise and eating habits (Friedman, 1993;
Habits and lifestyles formed during these years are likely to continue throughout life (Hamburg et al., 1993; Jessor, 1984; Susman et al., 1992). In addition, during adolescence and young adulthood, many consequential life decisions are made concerning educational attainment, occupational choices, relationship and family formation, and lifestyle options, making adolescence an important formative period likely to yield long-term benefits of health promoting efforts. In adolescence, as in adulthood, behaviours that may compromise well-being are an integral and pleasurable part of personal lifestyles. Risky behaviours such as smoking, drinking, and sexual activity can fulfil certain essential functions for adolescents such as identity exploration, coping with stress, gaining admission to or acceptance by certain peer groups, opposing adult authority, or indicating a transition to a more mature status (Hurrelmann, 1990; Irwin & Millstein, 1992; Maggs, Almeida, & Galambos, 1995; Silbereisen & Noack, 1988).

Adolescent’s relationships with their families furnish a fundamental base from which they begin to launch themselves into the adult world. Family relationships that balance connectedness with autonomy seem to promote optimal adolescent and young adult development. At the same time, the peer group plays a central role in socialization. Relationships with same age friends and peers tend to be more egalitarian than relationships with adults, providing adolescents with unique and important opportunities for self-expression and leadership. As adolescents move toward psychosocial maturity and adult relationships, experiences with their families, peers and romantic partners have great potential to facilitate or hinder healthy development.

The specific life context of adolescents, and particularly the psychosocial functions of health-damaging behaviours within that context, has received relatively little empirical attention (Franzkowiak, 1986; Irwin & Millstein, 1992; Silbereisen, Noack, & Schoenpflug, 1994). Consequently, prevention efforts based solely on knowledge acquisition and fear arousal have failed to appeal to adolescent’s ways of thinking about life in general and health in particular, due to their focus on illness prevention and their neglect of much more urgent personal and social needs (Dielman, 1994; Hansen, 1992; Millstein, 1993). Health promotion efforts should assist adolescents to cope with and fulfill their normative developmental needs in a constructive manner. When attempting to promote optimal development, intervening only at the individual level is just one option,
and often not the ideal one (Lerner et al). Part of an effective health promotion effort might be to attempt to increase young people's knowledge of and capacity to cope with pubertal and cognitive changes, along with other normative and non-normative transitions (Compas et al., 1993; Petersen et al., 2010). The meaning of these developmental transitions and their impact on adolescent health are heavily influenced by proximal social and educational contexts as well as distal sociocultural contexts.

**Understanding the factors for enhancing Eating Behaviours**

The college years are a period of significant change in the lifestyles of young adults. Eating patterns established during college are probably to be maintained for life and may have ongoing influences on college students’ health and their families’ health in the future (Brown, Dresen, & Eggett, 2005). According to several researchers college students have unhealthy eating behaviours; including skipping meals (Huang et al., 1994), frequent snacking on energy-dense food (Skinner, Salvetti, & Penfield, 1984), and engaging in unhealthy weight loss methods (Liebman et al., 2001). College life is very different compared to that of early adolescence. The physical, mental, and social changes that occur during college life can affect eating behaviours and nutritional health. College students face many health issues, such as alcohol abuse, chronic disease, common cold, and sexually transmitted diseases (Lowry et al., 2000; Shaffer et al., 2005; Wechsler et al., 1999). Also many environmental factors impact students and cause them to behave in specific manners when it comes to food, drinking, and exercise choices (Lowry et al., 2000; Rozin, Bauer, & Catanese, 2003). These influences can affect body weight and health (Hoffman et al., 2006). Especially, weight gain is expected for first-year students and continues to be perpetuated among young adults. Few researchers reported that excess weight gain during the freshman year is due to intake of high-calorie food, increase consumption of alcohol and unhealthy foods (Butler et al., 2004; Levitsky et al., 2004). Not only freshman but all young people face various health problems, such as iron deficiency, eating disorders, obesity, poor nutrition, and dental caries (Horacek & Betts, 1998).

Nicklas et al. (1998) found that Poor eating habits such as skipping breakfast may affect concentration, learning ability, and school performance, and college students who skipped breakfast had lower daily energy levels, and vitamin mineral intakes compared to
others. Generally, dietary inadequacy was two to five times higher for young people who skipped breakfast than for young people who ate breakfast (Nicklas et al., 1998). Eating away from home, concern about physical appearance, body weight, and heavy schedules all have an effect on eating patterns and food choices (Story et al., 2002).

Today, we live in a media-flood environment that has undergone innovative change during the last two decades (Story et al., 2002). The surroundings of today’s young people, their homes, schools, automobiles, and bedrooms, are filled with media of all kinds. They can choose among many television channels, radio stations, videos, and an infinite number of websites (Subrahmanyam et al., 2001). Television is the favourite advertising medium used by the food industry (Gallo, 1999). Exposure to food advertising, such as fast food, convenience food, and soft drinks can affect a viewer’s food choices (Story et al., 2002). A study found that 61% of adult informants ignored healthy eating when dining out because they associate restaurant eating with hedonism and pleasure (Middleton, 2000). People do not consciously think about health while eating, particularly when eating out, which reinforces that care is needed regarding what is offered by food establishments (Middleton, 2000).

**NEED FOR THE PRESENT STUDY**

The passage from adolescence into young adulthood is a major developmental transition during which discontinuity in life trajectories increases (Schulenberg et al., 1994; Sherrod et al., 1993). This major developmental transition represents the co-occurrence of at least two major role changes: the transformation from being a high school student to a university student and from being a child living at home to an independent person living in the college. Living on one's own greatly increases opportunities for self-governance in that it allows or forces the individual to make daily decisions about time use, lifestyle choices.

The passage toward adult roles, relationships, and responsibilities involves fundamental changes in every domain of life. Experiences and decisions during adolescent years have the potential to build character and competence, develop skills for coping with life's challenges, and enhance health and well-being. At the same time, normative and non-normative developmental transitions expose adolescents to many
challenges and hazards that may jeopardise their optimal development and health. A central element in the concept of health promotion is the idea of attempting to prevent the emergence of disorders and impairments to health at an early stage and to improve well-being and the quality of life (Noack, 1987). The earlier such support and assistance can be introduced, the greater the chance of avoiding the development of chronic disorders, impairments, and their consequences (Hurrelmann et al., 1987).

A central precise is that through greater understanding, facilitation, and support of these transitions, young adult’s health and well-being will be enhanced and optimal development will result. The basic issues concerning the factors affecting eating behaviour in young adults are discussed and also how through a psycho-education, health promotion can be attained, so that, it may prevent further problems caused due to unhealthy eating behaviours.