

Conferences of the European Health Psychology Society and The Division of Health Psychology of the British Psychological Society; Reflections of a PhD student

Tom St Quinton As a PhD student, I attended both the annual conferences of the European Health Psychology Society (Padua, Italy) and the Division of Health Psychology of the British Psychological Society (Cardiff, UK). There appeared to be a divide between both conferences concerning the present and future of health psychology. On the one side was the scientific progression of health psychology presented in Padua which included presentations pertaining to the systematic development, implementation and evaluation of theoretically informed behaviour change interventions. On the other side, however, was a backlash against systemisation presented in Cardiff. These criticisms were debated within an Expert Discussion entitled "Inspiration versus perspiration: Will systemisation bury or elevate health psychology?"

The arguments offered against the systematic approach were some of those expressed in Ogden's paper arguing for variability rather than systemisation (see Ogden, 2016). Some of these arguments included concerns that systemisation leads to 1) an underappreciation of psychologists' work due to the 'dumbing down' of our science, 2) the impression that 'Everyone' can do behavioural psychology, and 3) a restriction of innovate and creative thinking, with box approaches preferred. It was also suggested that not only don't current taxonomies of behaviour change techniques (BCTs) include all techniques, it would not actually be achievable to do so. Furthermore, it was suggested that there is a lack of empirical evidence in favour

of the systematic approach, in particular to change the behaviour of individuals. The hope was therefore that systemisation could be replaced by an alternative paradigm in the near future.

Although there is some merit to some of these assertions, the systematic approach certainly has many benefits. A coherent language through taxonomies helps with understanding the content of BCTs and what certain interventions consist of, particularly for early career researchers like myself. As a consequence of this coherence, communicating the active ingredients with relevant others (i.e., supervisors, designers etc) also becomes achievable. This clarity could have, perhaps, led to the conclusion that health psychology is 'easy' and that merely providing the tools will lead to instant successful change. Although these false perceptions may be annoying, it is better to be able to explain things simply than to not be able to explain them at all.

The systematic approach also facilitates in understanding the potential efficacy of techniques and those which could be more efficacious under certain circumstances. Concerning the former, for example, self-monitoring has been found to be an effective method in altering different behaviours (Michie, Abraham, Whittington, McAteer, & Gupta, 2009). Concerning the latter, mapping BCTs to psychological determinants has been a recent, yet underdeveloped, area of research. Research has thus only suggested what could be effective in changing specific determinants, with empirical evidence lacking to support these suggestions. This lack of evidence, however, can be addressed through the implementation of randomised control

trials (RCTs). Such studies are starting to replace the number of correlational studies, thus allowing conclusions of causality. As such, integrating the systematic approach within RCTs could, in time, help establish the most effective BCTs, the ideal number of BCTs, and the right combination of BCTs. Therefore, although it is not clear what works yet, the recent surge in RCTs could be able to shed light on these issues in due course.

In terms of changing individual behaviour, progress has been made recently in the designs used to do so. Studies have tended to use between-subject designs to change the psychological processes outlined in within-subject theories. However, such designs fail to account for interindividual differences between participants. For example, a formative study showing attitude to be a relevant construct to target within an intervention may have participants within the sample with already strong attitudes. As such, an intervention attempting to alter this particular construct would be ineffective in at least some of the participants. Similar to variability between participants, there may also be variability within an individual. Intraindividual variability can be seen in an individual with high efficacy beliefs one day and low beliefs the next. To attend to these issues, N-of-1 studies have been used recently to tailor interventions and test the effectiveness of BCTs (Nyman, Goodwin, Kwasnicka, & Callaway, 2015). Such work may be important in changing individual behaviour, particularly through matching specific BCTs with the relevant and appropriate psychological processes.

To conclude, there was (in my opinion anyway) a clear difference between the content discussed at the recent European Health Psychology Society conference and the Division of Health Psychology of the British Psychological Society conference. Although the former place emphasis on developing an overarching model, using coherent language, establishing effective change methods etc, some within the latter are not convinced. Nevertheless,

this approach has certainly allowed for some significant developments in the field, developments which have enabled PhD students like myself to create and deliver behaviour change interventions.

As the purpose of this brief commentary was to just highlight the observed discrepancy between the two conferences, more detailed arguments can be found in Ogden's paper (Ogden, 2016) and the proceeding responses (i.e., Abraham, 2016; Johnston, 2016; Teixeira, 2016), as well as the Expert Discussion itself (available at <https://www.youtube.com/watch?v=m7necMzYF08>)

References

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