

## ask the expert

by Emely de Vet and Justin Presseau

As a new feature of the EHP, and starting in the March 2009 issue, we are introducing a new section called “Ask the Expert”. In each issue a particular topical question will be answered by experts in health psychology or related fields. The EHP invites all readers to send their burning questions and suggested experts to the editors for the next issues of the EHP. For this first “Ask the Expert” we have posed the following question:

### Are implementation intentions a panacea for health behaviour change?

Background: Implementation intentions (Imps) are if-then plans specifying when, where and how one will act in order to achieve a goal (“If I encounter situation X, then I will perform behavior Y”; e.g. “If I arrive at work in the morning, then I will take the stairs instead of the elevator to my office”) (Gollwitzer, 1993; 1999). By forming imps individuals commit themselves to acting as soon as the specified situation is encountered. Forming implementation intentions has been proposed as a potentially effective and inexpensive intervention, particularly suited to help people to act upon their positive intentions. Meta-analyses showed that imps interventions may be a powerful tool in changing a range of health behaviors (e.g., Gollwitzer & Sheeran, 2006). But are implementation intentions a panacea for health behaviour change?

“It is important to remember that implementation intentions apply to positive intenders. From a public health perspective, this limits its potential effect. For instance, individuals who have a negative intention will not plan “when”, “where”, and “how” to adopt a given health behaviour. For these individuals, other approaches than implementation intentions will be required to favour behavioural change. Moreover, even if a substantial proportion of individuals are holding positive intentions but fail to act, it remains possible that true barriers are responsible for this situation. This would limit its use for less volitional behaviours. In conclusion, there are several issues that need to be addressed before claiming that implementation intentions represent a “panacea” for behavioural change, particularly from a public health perspective.”



**Prof Gaston Godin**  
Université Laval, Canada

“There is substantial variation in the techniques that are reported as prompts to form implementation intentions: there is no single implementation intention intervention. In addition, several studies have reported moderating effects of motivational, personality and plan related factors. Whilst intention appears to be a clear limiting factor, others such as conscientiousness show apparently conflicting findings. Moreover, there has been insufficient research on the effect of qualities of the cue and of the relationship between the chosen cue and the chosen response to know whether these might moderate the efficacy of the technique. Given these considerations, one would expect that future research will demonstrate further limitations of the technique as well as enhancements.”



**Dr Ian Kellar & Prof Stephen Sutton**  
Cambridge University, England

“Since Gollwitzer (1993) first introduced the concept (a) implementation intention formation has been found to promote the accomplishment of a variety of self-regulatory tasks (e.g., getting started, shielding goal striving from unwanted influences) that facilitate the translation of goal intentions into action, (b) research has clarified the mechanisms of implementation intention effects (enhanced cue accessibility, strong cue-response links, automaticity of action initiation), and (c) studies have identified several key moderator variables. For instance, forming an implementation intention can only be expected to benefit goal attainment when goal intentions are strong, activated, and self-concordant, and there is a ‘gap’ between intention and action. Implementation intention formation is a powerful self-regulatory tool but there is no panacea for health behaviour change.”



**Prof Paschal Sheeran**  
University of Sheffield, England



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“Action planning (=implementation intention) constitutes one out of several factors that have been found very beneficial in motivated participants of health promotion programs. However, in less motivated persons (so-called non-intenders) there is not much evidence that planning helps. Thus, planning is one important volitional (=post-intentional) construct, among others, that should be considered for interventions addressing motivated individuals. Other constructs are, for example, action control and perceived self-efficacy. If clients are not self-efficacious they cannot translate their plans into action.”



**Prof Ralf Schwarzer**  
Freie Universität Berlin, Germany

“The evidence supporting the influence of implementation intentions (II) could be summarized in a statement that compared to a lack of any intervention II seems to be a good tool if we need to induce a short-term change in self-reported behaviours. Certain discrepancies in research protocols (e.g., individualized approach including training in forming precise plans; filling in an implementation intentions form once or on multiple occasions) make it difficult, however, to generalize this prediction for any strategy used to form plans. Further, it may be expected that research will soon provide more evidence for the role of moderators and mediators restricting (or enhancing) the effectiveness of making plans. Clearly defined moderators (e.g., cognitive abilities, personality variables, baseline cognitions and habits) would allow for the identification of the populations in which II would be the most beneficial. Finally, in my opinion, to label II a panacea for health behaviour change we may need some more convincing evidence indicating that II is indeed better than “standard care” (as suggested in the Consort guidelines), instead of just proving that II may be better than a lack of any psychological intervention.”



**Prof Aleks Luszczynska**  
University of Colorado, USA

“The implementation intention (imps) research programme has made major contributions to our understanding of behaviour change by providing a theoretically sound approach, proposing simple, applicable intervention techniques that target behaviour directly rather than through distal predictors. However, most studies of action planning interventions for health behaviour change differ substantially from the rigorous laboratory-based paradigms developed by Gollwitzer, Sheeran and Webb (2006) to test the effects, mediators and moderators of imps. Obvious differences include a) in health psychology, participants are usually asked to form personally meaningful action plans, rather than being provided with researcher-specified imps, b) most health behaviour studies test the effects of action planning on general (unconditional) levels of behaviour performance (e.g., physical activity) rather than on conditional behaviour (e.g., levels of physical given that the ‘if’ condition of the implementation intention occurs) and c) initial experiences of enacting a personally meaningful action plan will affect learning and future performance in a way that is likely to differ from pressing keys in the lab. As a result, planning health behaviour change will differ from imps in terms of effects, mediators and moderators which I discuss in more detail in the paper “Towards a theory of intentional behaviour change: Plans, planning, and self-regulation” which will appear in the May 2009 issue of the British Journal of Health Psychology (Sniehotta, in press). Publication bias and variable methodological quality of planning studies indicates that more research is needed to understand when and how planning affects real-life behaviour.”



**Dr Falko Sniehotta**  
University of Aberdeen,  
Scotland

The editors would like to thank the respective authors for their contribution to *Ask the Expert*. If you have any questions or suggested experts to answer your questions, or you'd like to reply to any of the comments made in this section, please contact Emely deVet. ■

### References

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