volume 22 issue 9
December| 2022

www.ehps.net/ehp

The European Health Psychologist

Bulletin of the European Health Psychology Society

December 2022 Editorial

Angela Rodrigues
Northumbria University, UK
Pamela Rackow
University of Stirling, UK

Our final issue of 2022 includes various articles disseminating the activities undertaken by the different subdivisions of the EHPS, more precisely CREATE and the newly launched 'EHPS Ari Haukkala Mentoring Programme'. This issue also includes an interview with Dr Gerry Molloy, two keynote speakers' papers, and an opinion paper on healthcare guidelines in health behaviour change interventions.

A brief overview of the articles included in this issue can be found below.

Anila Allmeta and colleagues reflect on attending the **2022 CREATE workshop and EHPS conference.** This article also provides an account of key take home messages.

Milou Fredrix and colleagues introduce the newly launched 'EHPS Ari Haukkala Mentoring Programme'. The programme aims to support EHPS members with their research, professional and personal development.

The October 2022 EHP issue re-introduced the interview with an EHPS member feature. We have the pleasure of reading an **interview with Dr Gerry Molloy** (also a former EHP editor) on his exciting career journey to date and future endeavours.

Zuzana Dankulincova (keynote speaker at the 2022 EHPS Conference) provides an overview on how to implement what we know from health psychology into practice.

Urte Scholz (keynote speaker at the 2022 EHPS Conference) provide an overview of the role of dyadic relationships for health behaviours. This paper focus on the relevance of social relationships for health behaviours.

Cleo Protogerou and **Valerie F. Gladwell** provide an opinion paper on healthcare guidelines in health behaviour change interventions, where authors argue the benefit of investigating the accuracy and quality of health behaviour change interventions guidelines, by using established guideline appraisal frameworks.

Finally, we end this issue with by introducing the **new EHPS Executive Committee Members 2022-2024.**

Hope you enjoy reading this issue!
Angela Rodrigues & Pamela Rackow

Angela Rodrigues
Department of Psychology,
Northumbria University, UK
angela.rodrigues@northumbria.ac.uk

Pamela Rackow
Faculty of Natural Sciences,
Psychology, University of Stirling
pamela.rackow@stir.ac.uk

Report

Reflections of the 2022 CREATE workshop and EHPS conference

Anila Allmeta
University of Bayreuth, Germany
Márcia Carvalho
University of Galway, Ireland
Jennifer Dunsmore
University of Aberdeen, Scotland
Sarah Labudek
Heidelberg University, Germany
Alea Ruf
Goethe University Frankfurt, Germany
Charlene Wright
Griffith University, Australia

Introduction

Two and a half years on from the start of the COVID-19 pandemic, the European Health Psychology Society (EHPS) 36th annual conference was finally held in Bratislava, Slovakia. We were fortunate to be awarded the Collaborative Research and Training in the European Health Psychology Society (CREATE) grant to attend 2022 CREATE workshop and the EHPS annual conference. We are six female researchers from different countries, continents, career stages, and research areas, and were excited to learn, network, and enhance our research skills in the fun and collaborative settings of CREATE and EHPS.

Scientific programme

The number of great posters, oral presentations, state-of-the-art-presentations, symposia and roundtables at this year's EHPS conference was incredible. On the first conference day, Esther Papies gave an inspiring state-of-the-art presentation on "Health Psychology and climate change: Time to address humanity's most existential crisis" (slides available here). Her key messages were: "Climate change is a health emergency. Health psychologists are needed". We do not only have to take on responsibility as individuals, but also as health psychologists and as a scientific society. Health psychologists have key skills which are needed to change individuals' behaviour as well as systems to address this crisis. Therefore, it is great to see EHPS discuss and take action to be more sustainable. A position paper on "How to make EHPS conferences more climate friendly" was published in the March Issue of The European Health Psychologist. To show the dedication to sustainability at EHPS 2022, one vegetarian/vegan lunch was announced on twitter. Unfortunately, the vegetarian/vegan lunch turned out a bit 'fishier' than expected. We agree with Maya Braun's tweet: "We need to be better next year". Why not try a completely meat-free EHPS in 2023? And provide clear food labels? Why not team-up with interrail instead of Lufthansa for EHPS 2023 as suggested by Christiane Büttner on Twitter? We couldn't agree more with Esther's final thoughts: "Let's not be part of the problem. Let's not be the silent majority, the inertia, the status quo. When, if not now?".

As the conference progressed, the poster sessions offered a wide range of topics where everyone could find a spark of inspiration or new perspectives to an already familiar subject. On the third day of the conference a very interesting roundtable took place: "Mind the digital divide - How to reduce social inequalities in digital health promotion?". Based on their research and expertise, Laura König, Max Western, Eline Smit, Efrat Neter and Falko Sniehotta presented their views on the topic and then opened the floor to input from the numerous attendees. Not only was the current evidence on social inequalities in digital health promotion presented, but also possible reasons for the digital divide including potential psychological mechanisms and digital health literacy. In the following small group discussion, attendees had the opportunity to discuss future research and action-oriented solutions with the panelists. The results of these discussions are planned to be summarized in a white paper in order to not only stimulate discussion within the health psychology and public health community, but also the development and implementation of the solutions in practice. As early career researchers, we are looking forward to such inspiring collaborations on this highly relevant topic. The next opportunity to discuss this topic will be at next year's workshop "Understanding the digital divide in health promotion" (more information here:https://twitter.com/DigiDivideNet).

Meet the expert

There is no EHPS conference without meeting the experts. This year, four keynote speakers (Zuzana Dankulincová, Susan A. Murphy, Urte Scholz, Falko Snoehotta) were invited to meet with early career researchers and discuss scientific as well as career-related topics.

Falko Sniehotta holds the Professorship of Public Health, Social and Preventive Medicine at Heidelberg University since January 2021 after having worked at New Castle Univeristy (UK) and University of Twente (Netherlands). He has conducted innovative research in the field of weight loss management and contributed to advancing health psychology theory, for example, a position paper arguing that it's 'time to retire the theory of planned behavior'. Christine Emmer, Thomas Gützlow, Claire Riley, and Sarah Labudek met Falko Sniehotta in a small café in Bratislava, right next to a national ceremony that was under way(including the performance of a brass band). Right from the beginning, Falko insisted to call the meeting 'experts' meeting' and appreciated the work of everyone. During the meeting, an inspiring discussion about the possibilities and challenges for public health promotion in Germany, the Netherlands, and the UK evolved. Falko also gave some insights into the task of setting up a new professorship. As well as hiring a diverse and skillful team of researchers, he also wants to bring research to people (instead of the other way around), which is why he bought a van which will be equipped to conduct research within hard-to-reach populations. We thank Falko again for his time and the opportunity to share our thoughts.

Susan A. Murphy is an American Professor of Statistics and of Computer Science and leader in constructing adaptive interventions for use in informing clinical decision making and constructing just-in-time adaptive interventions delivered by mobile devices. Meeting up in the afternoon Bratislava sun, Matthias Aulbach, Maya Braun, and Charlene Wright pulled up a seat outdoors with Susan. Susan gave a lot of time to speak with each of us and getting to know our background and interests. During the meeting, we chatted about all things data, personalization, and digital health. Specifically we talked about i) the potential for collaboration between behavioral and computer science researchers and at what stage of the research progress computer scientists are best to be involved in such projects, ii) challenges of Ecological Momentary Assessment (EMA) and if it requires burden on the individuals to collect information, iii) the combination of passive sensors/ objective data and self-report data and iv) methods for more potent digital health interventions including the multiphase optimization strategy (MOST) and the sequential multiple assignment randomized trial (SMART). It was such a pleasure to have such insightful yet genuine conversations with Susan and we thank her again for her time and shared wisdom.

Networking

Due to the COVID-19 pandemic, for some of us, this was the first opportunity to attend a workshop and an international conference in person since embarking on our PhD journey. For a PhD scholar, the opportunity to network with fellow PhD scholars, meet international researchers and disseminate research findings are among the most important activities to improve our research and potentially enhance our career prospects.

While participating in the conference was invaluable to disseminate the findings of our PhDs, the conference also provided a unique opportunity to develop our professional networks. The coffee breaks allowed us to follow up with the audience members who asked questions about our presentation, meet fellow PhD scholars from across the world, and approach senior researchers with expertise in the field of our PhDs. These informal and more relaxed moments allowed us to engage in intellectually stimulating discussions about our PhDs, future research avenues, potential future research collaborations and research visits. We learned never to underestimate the more informal and social moments of a conference.

In addition to the professional benefits of attending and networking in person, the conference also provided opportunities to socialise and make new friends. We met at a CREATE mixer on the Sunday before the conference, which included a game to establish who were ‘dog’ or ‘cat’ people and two truths and a lie, which, for some got weird very quickly! Talking about the ‘normal’ stuff and sharing more about our research projects and career aspirations became easy – especially, if you had just been engaged in a bizarre conversation about webbed feet or finding out who played competitive e-sports.

Meeting other early career researchers at the CREATE workshop before the conference was beneficial. Throughout the week, having people that would always be happy to chat, or grab a coffee made the conference experience better. CREATErs attended talks together, sat in the sun and shared opinions on the topic of the day and supported each other by visiting presentations and posters of fellow members. Many of us continue the friendships created at the conference. Twitter and email have allowed us to share academic and personal stories since our meeting. We will continue to grow these friendships across the world and strengthen them every year at future CREATE workshops and EHPS conferences.

Conclusion

The CREATE workshop and the EHPS conference were unique opportunities to network, learn and discuss our research. We expanded our professional network and fostered collaborations that will improve our current research and contribute to our future professional careers. Furthermore, discussing our research with other researchers inspired us and left us looking forward to contributing to the development of health psychology in the years to come.

Attending the CREATE workshop and the EHPS conference was a privilege, and we are deeply grateful to the EHPS for granting us this opportunity. We thank the CREATE and EHPS committees that made this possible. We look forward to using the knowledge and experience we acquired during our PhD and research careers and making the most of the opportunities this grant has given us.

Anila Allmeta
Faculty of Life Sciences: Food, Nutrition and Health, Department of Public Health Nutrition, University of Bayreuth, Germany
anila.allmeta@uni-bayreuth.de

Charlene Alice Valerie Wright
School of Applied Psychology and Menzies Health, Griffith University, Queensland, Australia
charlene.wright@griffithuni.edu.au

Márcia Filipa Carvalho
Health Behaviour Change Research Group, School of Psychology, University of Galway, Ireland
M.Carvalho1@universityofgalway.ie

Jennifer Dunsmore
Academic Urology Unit, University of Aberdeen, Scotland
j.dunmsore.19@abdn.ac.uk

Sarah Labudek
Heidelberg University, Germany
science@sarahlabudek.de

Alea Ruf
Goethe University Frankfurt, University Hospital, Department of Psychiatry, Psychosomatic Medicine and Psychotherapy, Germany
alea.ruf@kgu.de

Original Article

Introducing the 'EHPS Ari Haukkala Mentoring Programme'

Milou Fredrix
Open Universiteit The Netherlands
Jan Keller
Freie Universität Berlin
Wendy Hardeman
University of East Anglia
Anne van Dongen
University of Twente
Karen Morgan
Royal College of Surgeons in Ireland & Perdana University, Malaysia
Liam Knox
University of Limerick
Jenny McSharry
University of Galway
Gerry Molloy
University of Galway
Angela Rodrigues
Northumbria University
Nikolett Warner
University of Galway
David French
The University of Manchester

As Mike Pegg said: "Great mentors provide a stimulating sanctuary in which people can take a helicopter view of their options" (The Art of Mentoring, 2005). This idea, among others, inspired an enthusiastic group of European Health Psychology Society (EHPS) members to launch the new 'EHPS Ari Haukkala Mentoring Programme'. The programme aims to support EHPS members with their research, professional and personal development. It is dedicated to Dr Ari Haukkala, an EHPS fellow who passed away in 2021. Ari Haukkala mentored, supervised and supported numerous EHPS members and was crucial in establishing health psychology research in Finland and built research capacity internationally.

This programme will launch at the start of 2023. In this article we would like to introduce the programme and the team behind it. For recent updates, keep an eye on the EHPS website (www.ehps.net) and the EHPS social channels (newsletter and twitter: @EHPSociety).

Dr Ari Haukkala, EHPS Fellow (1965 - 2021)

What does this programme entail?

The 'EHPS Ari Haukkala Mentoring Programme' is a programme of developmental mentoring aiming to support early and mid-career members with their research, professional and personal development by connecting mentors and mentees within the EHPS. The programme will create an online platform where prospective mentors and mentees will be formally matched by a dedicated team.

The programme uses developmental mentoring as the approach, whereby the mentor helps the mentee to discover solutions for themselves rather than providing opportunities [1]. The process is one of mutual learning; it is a developmental process for both parties and is based on experience instead of hierarchy. The role of the mentor, in general, is to help the mentee define challenges in relation to their research, career and personal development, discuss the choices and options the mentee could take, discuss the potential outcomes of these options, help the mentee decide on a solution to take forward, and define the next steps. The mentee, however, is in the driver's seat: they should be prepared to drive the mentoring relationship forward and take ownership of their learning. They identify their development goals and needs prior to and during the mentoring sessions and decide how they will work towards them. This mentee driven approach makes the time commitment for mentors minimal. Mentors and mentees agree and commit to a schedule of meetings, prepare for meetings and undertake any agreed actions. Both also commit to maintaining the confidentiality of the relationship.

Who is it for and how does it work?

Any early or mid-career EHPS member is a prospective mentee for the programme. This includes doctoral students but also post-doctoral researchers or early career lecturers who feel they could benefit from mentoring. Prospective mentors can be any EHPS member who could support a mentee through developmental mentoring. Prospective mentors do not need to hold a senior position, as mentoring can take place at all levels. If mentors or mentees express an interest in taking part, they will complete a brief profile on the EHPS website, including the areas in which they can provide mentoring or wish to receive mentoring in. A dedicated team will check responses in terms of suitability for mentoring and try to find an appropriate match. Once the matching process takes place, the prospective mentee will be sent the profile of the potential mentor for agreement first. If a mentor and a mentee are matched, the mentoring team will support the pair by providing training and resourses to stimulate a healthy and prosperous mentor-mentee relationship.

What are the benefits of taking part?

Previous evidence suggests that participating in a mentoring programme provided mentees with access to an impartial sounding board, helped mentees to identify training needs and courses, and supported mentees in making important progress towards long-term goals, and. In the UK, the National Institute for Health Research (NIHR) mentoring scheme for clinical academics showed that perceived benefits for mentees included receiving suggestions and fresh perspectives, becoming better clinical academic leaders, greater knowledge of career opportunities and how to enhance their (inter-)national reputation [2]. Evidence suggests that mentors also find mentoring a rewarding experience through promoting new skills or affirming existing skills. Other perceived benefits for mentors include contributing to the development of their profession, fostering the next generation of researchers, developing new knowledge and skills (e.g., leadership skills), and increased job satisfaction [2, 3].

How did the programme arise?

Wendy Hardeman, Jan Keller, Anne van Dongen, and Milou Fredrix initially developed a proposal to set up an international mentoring programme within the EHPS in 2021. The proposal was met with great enthusiasm and support by the EHPS Executive Committee. These core team members had been active within CREATE, SYNERGY or the EHPS Executive Committees and had experienced a need for mentoring within the EHPS community. The team felt there was a gap in terms of supporting researchers within the EHPS, which they were excited to try to fill.

A call was put out to all EHPS members to form a Task and Finish group in order to set up and pilot the mentoring programme. Led by the President-Elect of the EHPS EC (currently David French; formerly Wendy Hardeman), the Task and Finish group now consists of Karen Morgan, Liam Knox, Jenny McSharry, Nikolett Warner, Angela Rodrigues, Gerry Molloy, Milou Fredrix, Anne van Dongen, and Jan Keller. This group oversees the development, implementation and evaluation of a pilot of the mentoring programme and will prepare for the long-term implementation of the programme.

To include the EHPS community in the development of the programme, a survey was circulated to EHPS members to assess needs and requirements for a mentoring programme. Forty-two EHPS members filled out the survey with nearly all respondents expressing an interest in taking part in the programme and an enthusiasm for its suggested structure. The top 4 preferred topics that members would like to receive mentorship in were: 'general career development', 'writing funding grants', 'work/ life balance' and 'networking'. Topics that members would most prefer to provide mentorship were: 'presenting one's research', 'thesis writing', 'writing scientific articles', and 'general career development'. When asked what features the programme should look out for when matching mentors and mentees, 'Research Topic' and 'Skills' were seen as most important. However, many people commented that this should heavily depend on the needs and expectations of the mentee. Therefore, the programme will be conceptualized broadly and will not dictate mentoring topics beforehand.

The Task and Finish group took all the feedback of the EHPS community on board and has been working on finalising the programme ever since.

Wendy Hardeman, Angela Rodrigues, Milou Fredrix, Nikolett Warner, Jan Keller and Anne van Dongen, 6 of 10 members from the Task and Finish group, meeting in person at the EHPS conference 2022 in Bratislava

What's next and how can I sign up?

After many months of developing procedures, databases, training resourses as well as considering implementation and evaluation strategies, the pilot of the programme is now nearly ready to launch.

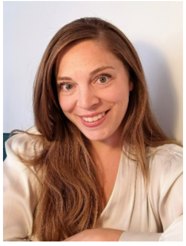
The first prospective mentors will be recruited in December 2022. Afterwards, the programme will be opened for prospective mentees in early 2023.

If you are interested in becoming a mentor. Please sign up now via at https://mentoring.ehps.net

If you are interested in becoming a mentee, please keep an eye on the EHPS website and social channels for the official launch of the programme. Participants of the pilot will be asked to take part in an evaluation of the programme, to help it grow and develop.

References

1.Solent University Southampton. https://www.solent.ac.uk/research-innovation-enterprise/researcher-support/research-mentoring (accessed 15/02/2021).
2.Academy of Medical Sciences. Supporting tomorrow's leaders today. The Academy of Medical Sciences' mentoring scheme for postdoctoral clinical academics. https://acmedsci.ac.uk/file-download/33984-50d44316cfb98.pdf (accessed 28/07/2020) [
3.Aberystwyth University. Coaching and mentoring policy. https://wwwaberacuk/en/media/departmental/humanresources/aberpoliciesprocedures/30733-Coaching-and-Mentoring-Policy--08-2015pdf (accessed 24/11/2020).



Milou Fredrix
Open Universiteit, The Netherlands
Milou.fredrix@ou.nl

Jan Keller
Department of Education and Psychology, Freie Universität Berlin, Germany
jan.keller@fu-berlin.de

Wendy Hardeman
School of Health Sciences, University of East Anglia, UK
w.hardeman@uea.ac.uk

Anne van Dongen
Department of psychology, Health and Technology, University of Twente, the Netherlands
a.vandongen@utwente.nl

Jenny Mc Sharry
University of Galway
jenny.mcsharry@universityofgalway.ie

Liam Knox
University of Sheffield, UK
L.Knox@sheffield.ac.uk

Gerry Molloy
University of Galway
Gerry.molloy@universityofgalway.ie

An interview with Dr Gerry Molloy

Gerry Molloy
University of Galway, Ireland

Gerry completed his PhD in the School of Psychology at the University of St Andrews in Scotland in 2005. He was then awarded a combined Medical Research Council/Economic and Social Research Council two-year post-doctoral fellowship that he held at the University of Aberdeen.

Following this he worked as a post-doctoral researcher in Epidemiology & Public Health in University College London and a Lecturer in Psychology at the University of Stirling. In 2012 he joined the academic staff in the School of Psychology at the University of Galway where he is now a Professor. He also is the Director of a research group focused on medication use across the lifespan.

EHP: Tell me a little bit about yourself and the job position you are currently in?

GM: Since 2012, I have been based in the School of Psychology at the University of Galway in the West of Ireland. I am a Professor in Psychology and Director of the MEDication across the Lifespan (MEDAL) research group. Between 2015 and 2021, I was the Director of the MSc in Health Psychology and I remain centrally involved in this course. My programme of research focuses on the behavioural science of medication use across the lifespan.

EHP: What is it like being a senior academic in a university?

GM: It is really enjoyable and stimulating to be working as an academic in a University. There is a relentless energy and an optimism, largely driven by the students, that is a privilege to experience on a daily basis. The way that academics work has changed quite dramatically since March 2020. We are spending more time engaging with others through a screen, which has some advantages, but we are all still adapting to this increase in online interaction. At times, the physical isolation has been quite disorientating. I have missed the quality on- campus interactions with students and colleagues over the last two years, therefore I am looking forward to getting back to more on campus activity over the next year. There can be great diversity in the types of activities you participate in when working as an academic. Teaching and research are obviously the core activities, but there are a whole host of ‘contribution activities’, such as equality, diversity and inclusion initiatives, which helps keep the role fresh and interesting.

EHP: What are your typical day-to-day tasks? Do they vary much?

GM: In theory it is supposed to be something close to 40% teaching, 40% research and 20% contribution, but this varies considerably from week to week. A typical week during the semester probably does amount to 2 days of teaching related activity, 2 days of research activity and 1 day of contribution. The teaching tasks are a mix of lectures, tutorials and teaching related assessment and administration. In recent years the research tasks are usually more research project management, review and supervision rather than collecting data, doing analyses and writing papers myself. I was able to do more of this hands-on work earlier in my career. A good deal of research time is now spent reviewing and providing feedback on others' research activity e.g., reviewing drafts of papers, theses, funding applications or other research material.

EHP: What were the main challenges in becoming a senior academic in a university? (i.e., previous training, applying for post-doctoral positions, applying for grants, other responsibilities, etc.)?

GM: At the start of my career when I was at the University of St Andrews in Scotland doing my PhD and later at the University of Aberdeen and then University College London, the main challenge was the precarious nature of the employment and the very limited financial means during this period. The length and duration of contracts and the financial pressures meant that a lot of physical, emotional and intellectual energy was spent on securing the next post, dealing with the practicalities of the relocation drudgery and adapting to the various new contexts that I worked in. While this lasted for the first seven years of my research career, my sense is that it is typical that many early career researchers spend much longer than this in short-term precarious fixed-term contracts. In many countries e.g., US, UK and Ireland, pursuing a senior academic career remains very challenging for those with limited additional financial supports early in their career. This is a significant problem in that there are very few senior academic leaders who originally come from socio-economically deprived communities. Given the critical importance of the social determinants of health, this selection bias against those from socially disadvantaged communities might shape the science in ways that might not meet the needs of those communities.

Over the last 10 years the biggest challenge has been trying to get the balance right between my academic work, being a parent of three young children and supporting my wife to develop her career. Increasingly it has been difficult to travel to conferences and engage in similar research networking and dissemination. One of the positives of the pandemic, however, has been the acceleration of online and hybrid conferences which have created opportunities to participate in a variety of events that was previously not possible.

EHP: What aspects of this journey have you enjoyed the most?

GM: I have been very fortunate in that everywhere I have worked has been endlessly interesting. Almost every day I see an academic event that I want to attend in some other part of the University or a training course that I want to take. One of the most enjoyable aspects of the academic journey is the constant opportunities to learn new things. The increasing widespread commitment to open scholarship has meant that there is no end to variety of events and training that you can participate in as an academic. I find that being immersed in this strong culture of continuous learning and development is invigorating. At the heart of this is the early career researchers who are often the developers or early adopters of new methods in both teaching and research. In my experience the "more knowledgeable other", to use a developmental term, is more often than not, a junior colleague. Thankfully, I still have quite a lot of interaction with PhD students and post-doctoral researchers who are invariably very willing and able to support the professional development of their "senior colleagues". This is one of the best aspects of the job.

EHP: Since completing your doctoral training, did you always want to be a lecturer? If so, why?

GM: I didn't know enough about what was involved in being a lecturer to be confident that was the path for me after my PhD. During my PhD I had limited involvement in lecturing, so it remained a bit of an unknown for me until I had contributed to teaching a bit more during my post-doctoral career. The only alternative that I had considered was to be researcher, but there didn't seem to be many opportunities to get a secure researcher job at post-doctoral level, so after a while it seemed like the most likely scenario was to pursue a lecturing post. Therefore, I started to build a portfolio of experience during my post-doctoral work that enabled me to secure a lectureship e.g., lecturing to different student groups and supervision of undergraduate and post-graduate projects.

EHP: When you think about your area of expertise and your research, what is the way forward to make even more impact- in the research community as well as in society?

GM: While it might seem obvious to early career researchers that comprehensive stakeholder engagement is essential throughout the research process to maximise the impact of research both scientifically and socially, this is a more recent realisation for me over the last 10 years. In particular, the continuous engagement with patient and public involvement (PPI) partners in research is essential to maximise impact. Generally, this stakeholder work is carried out with more forethought and as a core element of a programme of research, however there is still scope to significantly improve our methods in this regard. Maximising impact will require that we do more of this stakeholder engagement and do it better.

EHP: As psychologists in general, what is our impact on society and how can we achieve more impact (More public engagement, more interdisciplinary work)?

GM: The interdisciplinary work is essential. This requires effective cross-disciplinary communication, which in itself can facilitate better public engagement, because it requires us to translate our science for experts in other disciplines. This initial step of interdisciplinary research often gets us on the path to better public engagement. Psychology is having an increasingly greater impact on society over time and I think that this has been really amplified over the last two years. For example, the Irish prime minister said in a radio interview in 2020 that, "The psychology of a pandemic is as important as the physical presence of the virus", which sounds like a line taken from an introductory health psychology text. This kind of recognition of the value and impact of health psychology is very positive for the field.

EHP: Regarding Covid 19 and its impact on your research and teaching, what needs to go and what can stay?

GM: In relation to research, we need to maintain the extent of our excellent public engagement that we achieved during the pandemic, while being careful to avoid straying too far from our area of expertise. When given a public platform to comment on a highly charged topic, it takes a lot of restraint to avoid letting speculation and personal political biases colour our evaluations to a greater degree than reliable evidence, so we need to resist that temptation. When we comment on complex public health problems that have a high degree of uncertainty, a sense of humility might garner more public confidence in our analyses than an over-zealous commitment to one specific over-simplistic solution. As some esteemed EHPS Dutch colleagues once quoted, "Everything should be as simple as possible, but no simpler".

In the domain of teaching we need to add more value to the on campus experience for students than we have in the past. This will involve re-creating the social conditions for students to meet their fundamental needs for autonomy, competence and connection with others. The pandemic inhibited this to a great degree and we need to re-think how we design our teaching and learning so that students and staff can foster communities within which they can develop and flourish. Some of this will be facilitated by better use of technology, so we should embrace those new tools that have clearly added-value, while also getting back to more traditional forms of face-to-face interaction.

Principles from Universal Design for Learning (UDL) appear to have achieved a renewed level of prominence during the pandemic. In particular, I think that we need to enhance our use of short form video in teaching, learning and assessment and reduce the quantity of assessment that centre on written expression as part of our promotion of UDL. Proficiency in written expression remains a key academic skill, but knowledge and skills in the production of oral and visual content in short form video seems to be an increasingly valuable core communication skill. This could help recognise and reward those students who clearly have excellent oral communication skills, but who might have difficulties with written expression or who find live oral communication challenging. There is a lot of exceptional quality that our current methods of assessment might not identify.

Gerry Molloy
University of Galway, Ireland
gerry.molloy@universityofgalway.ie

Original Article

How to implement what we know from health psychology into practice?

Zuzana Dankulincova
Pavol Jozef Safarik University in Kosice, Slovakia

Increasingly voices within scientific community have been heard trying to make sure that the scientific knowledge generated will be translated to everyday practice and used as researchers are more aware of responsibility to the participants of their research. Anyone who asks respondents of their research to devote time to complete a questionnaire, to share their experience or to be a part of an intervention should have a clear idea of what they will do with the data. It is unethical to request this type of participation for no good reason (Coulter, 2013).

However, even though we researchers are aware of this ethical responsibility and we want for our research findings to have a clear practical implementation, it is often the case that the road from awareness of evidence to widespread implementation takes a very long time to travel (Lewis, Martens & Barre, 2009). Scientific knowledge is not always applied systematically or expeditiously to everyday practice. It now takes even more than a decade for knowledge to be incorporated into practice, and even then application could be highly uneven (Richardson et al., 2001). It seems that in spite of huge efforts, people fail to benefit optimally from scientific advances. Grimshaw, Eccles, Lavis and colleagues (2012) in their article on knowledge translation of research findings state that despite the investments, the health care system has failed to bring cost-effective services to a portion of those who need them and that there is evidence that in the US health care system, for example, around 20%–30% of patients may receive care that is not needed or is potentially harmful.

Why is it so, and what we could to about it? What are the roadblocks that might be encountered on the way? How can our research practices and research outcomes contribute more to health and social policy changes? The first and foremost question that should be on our minds and if not addressed properly could create a major roadblock on the way to our successful knowledge translation is: Are we really asking the important questions that will help lead to changes that we want to see? At the same time, no matter how well we package and communicate our research findings, our research will not contribute to change if it is not relevant for solving problems. Closely connected to that is the issue of problem-focused versus solution-focused research. Most of the studies are focused on problems, their identification, description, determination of their magnitude. Far less attention is given to the solutions of problems. In addition to that it is also important to realise that application of research findings is only one kind of research impact. Creating awareness, changing attitudes is also critical and can take a long time.

To be able to come up with relevant and solution-focused findings, we need to be intentional in our research decisions. As with the research aim, we need to be aware of what is it that we want to study and why before we design our research. No matter how precisely we decide to pursue applicability and translation of our knowledge, it is important to have a vision early on about the kind of change we want to contribute to. Our personal vision should be articulated. The vision we share with our academic and nonacademic partners will keep us together during the inevitable challenging times. It is always good to start with two questions that cover two crucial aspects of your research. Firstly - How can our research practices contribute to change? It concerns people that are involved in our research, relationships we have with each other and the activities that are done as a part of our research. Think about how and with whom we pursue our research activities. Secondly – How can our research products contribute to change? It concerns our findings, evidence being produced, information and ideas generated as a part of our research. Think about how we communicate our research evidence and expertise.

Thinking about the relevance, about applicability of our research in terms of our research practices and our research products is only the beginning on the road to the approach of translation of knowledge into practice. More answers are to be found in the knowledge translation approach. I am aware that even those who already heard about the concept of knowledge translation might be confused by and lost in other similar terms like Knowledge Transfer, Knowledge Exchange, Knowledge to Action, Knowledge Mobilization, Research Utilization or Research Transfer. Graham, Logan, Harrison and colleagues (2006) identified 29 terms used to refer to some aspect of the concept of knowledge translation. A review by McKibbon, Lokker, Wilczynski and colleagues (2010) identified 100 terms describing knowledge translation related research.

I am using the term knowledge translation here as described in 2000 by Canadian Institutes of Health Research as "the synthesis and ethically-sound application of knowledge within a complex system of interactions among researchers and stakeholders in order to accelerate the benefits of research through improved health, more effective services, and a strengthened health care system" (Canadian Institutes of Health Research, 2022). The most crucial aspect of this definition is the interaction between the knowledge user and the researcher, resulting in mutual learning. According to the Canadian Foundation for Healthcare Improvement knowledge translation is happening through knowledge exchange defined as "collaborative problem-solving between researchers and decision-makers that happens through linkage and exchange. Effective knowledge exchange involves interaction between decision-makers and researchers and results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making." (Canadian Institutes of Health Research, 2022).

Knowledge translation depends upon interaction and communication between researchers and research users. For this interaction to be successful, it is very helpful to be guided by four principles of knowledge translation: (1) Research Literacy, (2) Effective Communication, (3) Context and Policy Literacy and (4) Co-creating Knowledge. When it comes to the first principle – **Research literacy** – we should try and equip our audience to be able to receive, value and use our research. The second principle – **Effective communication** - is based on assumption that effective communicators is a two-way process. The better we listen to our audience, the better we'll be able to answer their needs and the more our messages will be believed, liked, and ultimately acted upon. No matter how well we package and communicate our research processes and findings, our research will not lead to impact if it is not relevant or usable. This is closely connected to the third principle – **Context and policy literacy**. Effective communication with our research users will help us to get informed about the specific **context** that matters and is relevant to us. Then we can be more intentional about our research and knowledge translation decisions. The fourth principle - **Co-creating Knowledge** - relies on, enhances, and incorporates the other three knowledge translation principles and go even further. This last step encourages us to collaborate directly with research users to co-create research knowledge. This overcomes the know-do gap, and the researcher-user gap with potential benefits for the research process itself, for us as the researchers and last but not least for the communities of research users themselves.

Two types of knowledge translation have been recognized by Canadian Institutes of Health Research: (1) the "**End of grant knowledge translation models**" and (2) the "**Integrated knowledge translation models**". In the End of grant knowledge translation, the researcher develops and implements a plan for making knowledge users aware of the knowledge that was gained during a project. Therefore, End of grant knowledge translation includes the typical dissemination and communication activities undertaken by most researchers, such as knowledge translation to their peers through conference presentations and publications in peer-reviewed journals. End of grant knowledge translation can also involve more intensive dissemination activities that tailor the message and medium to a specific audience. In Integrated knowledge translation, stakeholders or potential research knowledge users are engaged in the entire research process. By doing integrated knowledge translation, researchers and research users work together to shape the research process by collaborating to determine the research questions, deciding on the methodology, being involved in data collection and tools development, interpreting the findings, and helping disseminate the research results. This approach, also known by such terms as collaborative research, participatory action-oriented research, and co-production of knowledge, should produce research findings that are more likely be relevant to and used by the end users (Canadian Institutes of Health Research, 2022).

The research method that meets the principles of knowledge translation and with which we have extensive experience in our research team is concept mapping. Concept mapping is an integrated mixed method design based on the qualitative data collection and quantitative data analysis, enabling a diverse group of participants to qualitatively articulate their ideas as an answer for the focal research question raised by researchers and represent them in a variety of quantitatively derived results by developing a conceptual framework with a visual display of the clustering (Kane & Trochim, 2007). This method allowed us to apply a participatory approach, with participants' involvement and the empowerment, and to visualize the results in a way accessible and understandable for various groups of research users. This method could be used for different research topics and until now our research team used concept mapping (1) to examine how adults and children perceive the impact of social policies connected to unemployment on well-being in the household, and whether their views differ (Bosakova et al., 2019), (2) to examine what needs to be done to improve the system of care for adolescents with emotional and behavioural problems and to assess the urgency and feasibility of the proposed measures from the perspective of the care providers, (3) to explore the perceptions of various stakeholders and experts who may have an impact on the inclusion of Roma and/or their access to health care on how to improve health care access for Roma living in social exclusion in the Czech Republic (Svobodova et al., 2021), and (4) to assess which measures could improve the healthy early childhood development of children from marginalized Roma communities and to identify priority measures (Chovan et al., 2022).

Even though it might look as a straightforward process I can assure you, it is not. In order to achieve the moment where our work is in line with knowledge translation principles is very demanding on capacity, time and communication. It is therefore very important to appreciate that the work you are doing is difficult – and important!

References

Bosakova, L., Madarasova Geckova, A., Borrell, C., Hajduova, Z., van Dijk, J. P., & Reijneveld, S. A. (2019). How adults and children perceive the impact of social policies connected to unemployment on well-being in the household: a concept mapping approach. *International Journal of Public Health, 64*(9), 1313-1323.

Canadian Institutes of Health Research (2022). *Knowledge Translation*. Retrieved June 22, 2022 from http://www.cihr-irsc.gc.ca/e/29418.html

Chovan, S., Filakovska Bobakova, D., Bosakova, L., Madarasova Geckova, A., Reijneveld, S. A., & de Kroon, M. L. (2022). How to make healthy early childhood development more likely in marginalized Roma communities: a concept mapping approach. *International journal for equity in health, 21*(1), 1-15.

Coulter, A. (2013). *Understanding the experience of illness and treatment*. In Ziebland, S., Coulter, A., Calabrese, J. D., & Locock, L. (Eds.) (2013). Understanding and using health experiences: improving patient care. OUP Oxford.

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: time for a map? *Journal of continuing education in the health professions, 26*(1), 13-24.

Grimshaw, J. M., Eccles, M. P., Lavis, J. N., Hill, S. J., & Squires, J. E. (2012). Knowledge translation of research findings. *Implementation science, 7*(1), 1-17.

Kane, M., & Trochim, W. M. (2007). *Concept mapping for planning and evaluation.* Sage Publications, Inc.

Lewis, S., PJ Martens, and L. Barre (2009). *Estimating the return on investment for health services research: A theoretical and empirical analysis*. In C. Frank et al, eds. The ROI in Health Research: Defining the Best Metrics. Canadian Academy of Health Sciences.

McKibbon, K., Lokker, C., Wilczynski, N. L., Ciliska, D., Dobbins, M., Davis, D. A., & Straus, S. E. (2010). A cross-sectional study of the number and frequency of terms used to refer to knowledge translation in a body of health literature in 2006: a Tower of Babel? *Implementation Science, 5*(1), 1-11.

Richardson, W. C., Berwick, D. M., Bisgard, J. C., Bristow, L. R., Buck, C. R., & Cassel, C. K. (2001). Crossing the quality chasm: a new health system for the 21st century.

Svobodova, I., Filakovska Bobakova, D., Bosakova, L., & Dankulincova Veselska, Z. (2021). How to improve access to health care for Roma living in social exclusion: a concept mapping study. *International journal for equity in health, 20*(1), 1-14.

Zuzana Dankulincová
Associate Professor of Social Psychology, Department of Health Psychology and Research Methodology, Medical Faculty, Pavol Jozef Safarik University in Kosice, Slovakia

zuzana.dankulincova@upjs.sk

Original Article

The role of dyadic relationships for health behaviors: Opportunities and challenges

Urte Scholz
University of Zurich, *Switzerland*

Social relationships play an important role for people's mental and physical health (e.g., Holt-Lunstad et al., 2010). There are different pathways that could possibly explain this effect: For example, better social integration could lead to more social support from network members that in turn might reduce perceived stress, and promote health behaviors -both of which are important determinants of health (Berkman et al., 2000). Here, I will focus on the relevance of social relationships for health behaviors.

Health-relevant behaviors, such as eating, smoking, or physical activity oftentimes take place in a social context. For example, imagine someone who starts their day with having breakfast with their family, then eats lunch with colleagues from work, and enjoys dinner again with their family or with friends. In contrast to this social embeddedness of health-relevant behaviors, the vast majority of mainstream theories of health behavior focus exclusively on factors within individuals, e.g., attitudes, perceived behavioral control or subjective norm, that is the subjective perception of the social environment (Ajzen, 1991). External influences, such as social factors that go beyond the individual's perception and emerge from interactions with others are much less frequently and not in depth addressed in the health behavior literature. Consequently, even less frequent in the mainstream theories on health behavior change are dyadic approaches that take the perspectives of two people involved in the behavioral change into account (for an important exception, please see Huelsnitz et al., 2021).

Social exchange processes and health behavior

There is cumulating correlational research on the role of different social exchange processes, such as social support or social control for health behavior change. Social support, defined as the exchange between provider and receiver (Hogan et al., 2002), can take different functions with the most prominent ones being emotional and instrumental support. Emotional support contains caring, comforting, and soothing, while instrumental support refers to practical help, such as resource provision or problem solving (Knoll et al., 2018). Both forms of social support have been shown to relate to fewer cigarettes smoked in smokers intending to quit in both dual- and single-smoker couples (Lüscher et al., 2017; Scholz et al., 2016). At the same time, results of intervention studies aiming at increasing social support from various non-professional sources for smoking cessation show rather sobering effects on the behavior (Park et al., 2012; Schwaninger et al., 2021). This might in parts be explained by the interventions failing to increase social support in the first place. Thus, it is key to identify the conditions under which social support can be increased by interventions aiming at changing behavior and to examine under what circumstances increased social support is indeed serving as a mechanism to change the behavior (Rothman & Sheeran, 2021).

Another social exchange process, albeit less prominent than social support, is social control (Butterfield & Lewis, 2002). Social control aims at influencing and regulating another person's behaviors by means of specific interpersonal strategies (Butterfield & Lewis, 2002). These strategies are often distinguished into positive (e.g., discussions about the health behavior) and negative (e.g., using pressure) ones. In line with the extended dual-effects model of social control and a recent meta-analysis that was mainly based on cross-sectional studies (Craddock et al., 2015) we found across three daily diary studies on smoking and physical activity that positive social control was beneficially related to the health behavior and to feeling better, while negative control was unrelated to the behavior, but related to feeling worse and to more reactant responses, i.e., doing the opposite of what the partner wanted and hiding the unhealthy behavior (Scholz et al., 2021). The within-person effects primarily emerged on the same but not from the previous day indicating that daily social control seems to be a fast acting process. Future research on social control should further examine the conditions under and outcomes for which social control is beneficial. And this should preferably be investigated in people's everyday life and in dyads. In particular the motivation for providing positive and negative social control is underresearched, but would be necessary to know for allowing to reduce dysfunctional and increase beneficial dyadic social control interactions.

Dyadic interventions for health behavior change

Aside from social support and social control as two examples for interpersonal exchange processes that have been investigated in the context of people's health behavior change, there is a growing literature on dyadic interventions for promoting health behavior change. Overall, several systematic reviews, and meta-analyses report a certain superiority of dyadic interventions compared to individual-focused interventions (Arden-Close & McGrath, 2017; Carr et al., 2018; Richards et al., 2017). But there is a considerable heterogeneity regarding the population under study (e.g., healthy adolescents, adult patients), the dyadic constellation (e.g., romantic couples, peers, parent-child-dyads), the type of dyadic intervention (i.e., what role do the two partners play in the intervention), the behavior change techniques used in the dyadic interventions, the target of the behavior change (both dyad partners or only one), the kind of behavior targeted, the contexts of behavior change, and the time span considered in the intervention (Arden-Close & McGrath, 2017; Carr et al., 2018; Martire & Helgeson, 2017; Richards et al., 2017). Consequently, there is a great need for more systematization of dyadic intervention research. One starting point is the question what a dyadic intervention technique is and what kinds of intervention techniques there are. We introduced a continuum of intervention techniques ranging from individual techniques in a dyadic setting with the partner being present but passive, to dyadic techniques that require both partners to be actively involved in the intervention (i.e., joint techniques; Scholz et al., 2020). Moreover, as it was the case in behavior change interventions targeting individual behavior change before the behavior change taxonomies were introduced (Kok et al., 2016; Michie et al., 2013), there is a lack of systematization in reporting the content of the dyadic intervention techniques. In a recent systematic review on dyadic health behavior change, only three out of 14 intervention studies reported what couples were asked to do (e.g., identify ways the spouse could support the other's diet and activity programs), with all other studies not reporting specifics of the intervention content (Arden-Close & McGrath, 2017). This is a major problem in this field as it prevents accumulating knowledge with regard to the effectiveness of specific intervention techniques applicable in dyads. In an ongoing project that is funded by the Swiss National Science Foundation and the German Research Foundation we are currently working on the development of a compendium of dyadic intervention techniques (see https://osf.io/r43v6/). A first step of this project is a systematic review of the landscape of dyadic intervention techniques in romantic couples (PROSPERO, CRD42021261622; Villinger et al., 2022). In this review we categorized the different dyadic intervention techniques and descriptively present frequency in reporting across different health-related behaviors (i.e., HIV prevention, physical activity, etc.; Villinger et al., 2022). This work lays the ground of developing a prototype compendium / taxonomy that will subsequently be refined. With this project, we will contribute a first step to the much-needed systematization in dyadic interventions research.

Conclusion

The relevance of social relationships for health can in parts be explained by the mostly beneficial effects of social relationships on people’s health behaviors. Research on interpersonal processes, such as social support and social control, shows the opportunities, but also the complexity and challenges that lie in capitalizing social relationships for health behavior change. So far, the great heterogeneity prevents the accumulation of knowledge on which specific dyadic intervention techniques are effective (and under which conditions). More research is urgently needed to contribute to a systematization in this area and thereby allow a better understanding on how to best capitalize people’s social relationships for health behavior change.

References

Ajzen, I. (1991). The Theory of Planned Behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Arden-Close, E., & McGrath, N. (2017). Health behaviour change interventions for couples: A systematic review. *British Journal of Health Psychology, 22*(2), 215–237. https://doi.org/10.1111/bjhp.12227

Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine, 51*(6), 843–857. https://doi.org/10.1016/S0277-9536(00)00065-4

Butterfield, R. M., & Lewis, M. A. (2002). Health-related social influence: A social ecological perspective on tactic use. *Journal of Social and Personal Relationships, 19*(4), 505–526. https://doi.org/10.1177/0265407502019004050

Carr, R. M., Prestwich, A., Kwasnicka, D., Thøgersen-Ntoumani, C., Gucciardi, D. F., Quested, E., Hall, L. H., & Ntoumanis, N. (2018). Dyadic interventions to promote physical activity and reduce sedentary behaviour: Systematic review and meta-analysis. *Health Psychology Review, 1–69*. https://doi.org/10.1080/17437199.2018.1532312

Craddock, E., vanDellen, M. R., Novak, S. A., & Ranby, K. W. (2015, March). Influence in relationships: A meta-analysis on health-related social control. *Basic and Applied Social Psychology, 37*(2), 118–130. https://doi.org/10.1080/01973533.2015.1011271

Hogan, B. E., Linden, W., & Najarian, B. (2002). Social support interventions. *Clinical Psychology Review, 22*(3), 381–440. https://doi.org/10.1016/S0272-7358(01)00102-7

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. *PLoS Medicine, 7*(7), e1000316. https://doi.org/10.1371/journal.pmed.1000316

Huelsnitz, C. O., Jones, R. E., Simpson, J. A., Joyal-Desmarais, K., Standen, E. C., Auster-Gussman, L. A., & Rothman, A. J. (2021). The Dyadic Health Influence Model. *Personality and Social Psychology Review, 26*(1), 3–34. https://doi.org/10.1177/10888683211054897

Knoll, N., Scholz, U., & Ditzen, B. (2018). *Social support and family processes.* In T. A. Revenson & R. A. R. Gurung (Eds.), The Handbook of Health Psychology (3rd ed., pp. 279-289). Psychology Press.

Kok, G., Gottlieb, N. H., Peters, G.J. Y., Mullen, P. D., Parcel, G. S., Ruiter, R. A. C., Fernández, M. E., Markham, C., & Bartholomew, L. K. (2016). A taxonomy of behaviour change methods: An intervention mapping approach. *Health Psychology Review, 10*(3), 297–312. https://doi.org/10.1080/17437199.2015.1077155

Lüscher, J., Stadler, G., & Scholz, U. (2017). A daily diary study of joint quit attempts by dual-smoker couples: The role of received and provided social support. *Nicotine & Tobacco Research, 20*(1), 100–107. https://doi.org/10.1093/ntr/ntx079

Martire, L. M., & Helgeson, V. S. (2017). Close relationships and the management of chronic illness: Associations and interventions. *The American Psychologist, 72*(6), 601–612. https://doi.org/10.1037/amp0000066

Michie, S., Richardson, M., Johnston, M., Abraham, C., Francis, J., Hardeman, W., Eccles, M. P., Cane, J., & Wood, C. E. (2013, August). The behavior change technique taxonomy (v1) of 93 hierarchically clustered techniques: Building an international consensus for the reporting of behavior change interventions. *Annals of Behavioral Medicine, 46*(1), 81–95. https://doi.org/10.1007/s12160-013-9486-6

Park, E. W., Tudiver, F. G., & Campbell, T. (2012). Enhancing partner support to improve smoking cessation. The Cochrane Database of Systematic Reviews, 7, CD002928. https://doi.org/10.1002/14651858.CD002928.pub3

Richards, E. A., Franks, M. M., McDonough, M. H., & Porter, K. (2017). 'Let's move:' a systematic review of spouse-involved interventions to promote physical activity. *International Journal of Health Promotion and Education, 56*(1), 1–17. https://doi.org/10.1080/14635240.2017.1415160

Rothman, A. J., & Sheeran, P. (2021). The operating conditions framework: Integrating mechanisms and moderators in health behavior interventions. *Health Psychology, 40*(12), 845–857. https://doi.org/10.1037/hea0001026

Scholz, U., Berli, C., Lüscher, J., & Knoll, N. (2020). *Changing behavior using dyadic interventions*. In M. S. Hagger, L. Cameron, K. Hamilton, N. Hankonen, & T. Lintunen (Eds.), The Handbook of Behavior Change. Cambridge University Press.

Scholz, U., Stadler, G., Berli, C., Lüscher, J., & Knoll, N. (2021). How Do People Experience and Respond to Social Control From Their Partner? Three Daily Diary Studies. *Frontiers in Psychology, 11*, 3893. https://doi.org/10.3389/fpsyg.2020.613546

Scholz, U., Stadler, G., Ochsner, S., Rackow, P., Hornung, R., & Knoll, N. (2016). Examining the relationship between daily changes in support and smoking around a self-set quit date. *Health Psychology, 35*(5), 514–517. https://doi.org/10.1037/hea0000286

Schwaninger, P., Berli, C., Scholz, U., & Lüscher, J. (2021). Effectiveness of a Dyadic Buddy App for Smoking Cessation: Randomized Controlled Trial. *Journal of Medical Internet Research, 23*(9), e27162. https://doi.org/10.2196/27162

Villinger, K., Di Maio, S., Gawrilow, C., Knoll, N., Scholz, U., Stadler, G., & Berli, C. (2022). Compendium of dyadic intervention techniques (DITs) to change health behaviors: A systematic review. Manuscript in Preparation.

Urte Scholz
Professor of Applied Social and Health Psychology, University of Zurich, Switzerland
urte.scholz@psychologie.uzh.ch

Opinion Article

Healthcare guidelines in health behaviour change interventions: Quality appraisal and implementation.

Cleo Protogerou
University of Crete, Greece
Valerie F. Gladwell
University of Suffolk, UK

Abstract

In this position paper, we note that appraisals of health behaviour change interventions (HBCIs) focus on identifying intervention particulars (e.g., techniques, design, theoretical underpinnings, psychological mechanisms, delivery modes) most prominently and consistently associated with desired behaviour change. However, a key aspect of interventions, the implemented healthcare guidelines, do not undergo intensive scrutiny in intervention research. We provide evidence to show that available healthcare guidelines may be flawed, and as such, may result in ineffective interventions and potential harms for guideline and intervention recipients. We therefore argue that HBCIs would benefit from investigating the accuracy and quality of the embedded guidelines, by using established guideline appraisal frameworks, and we provide examples of how this can be, systematically, done.

Keywords: *health behaviour change interventions; healthcare guidelines; healthcare accuracy and appraisal; the Practice Guidelines Evaluation and Adaptation Cycle (PGEAC) framework.*

Risk-taking behaviours, such as substance abuse, unhealthy eating, and lack of exercise, are among the strongest contributors to disease and to total and cause-specific mortality across nations (Kvaavik et al., 2010). Accordingly, health promotion efforts have focused on preventing or reducing risk-taking behaviour through health behaviour change interventions (HBCIs), which comprise of coordinated sets of activities designed to change health behaviour patterns (Beard et al., 2019). Health psychology research is at the forefront of HBCI development and appraisal (Presseau et al., 2022), with appraisal efforts focusing on establishing components of successful HBCIs. Intervention appraisal research, typically conducted via evidence syntheses, has identified behaviour change techniques linked to change; psychological mechanisms through which behaviour change techniques exert their effect; theoretical determinants of behaviour change; components of cost-effective HBCIs; methodological design, recipient, and environmental/ contextual features associated with successful HBCIs; and optimal ways to tailor and frame HBCI health messaging (Beard et al., 2019; Carey et al., 2019; Michie et al., 2013; Pope et al., 2017; Protogerou & Johnson, 2014; Protogerou et al., 2018). Intervention research has also focused on formative evaluations of HBCIs (e.g., assessment of programme creation, adequacy of theoretical and empirical basis, and cultural adaptation); input evaluations (e.g., assessment of resources, such as funding, staff numbers and training, facilities and equipment); process evaluations (e.g., assessment of recipient experience, acceptability, feasibility, fidelity, dose, and reach); and output evaluations (e.g., appraisal of documentation of measurable products, such as number of sessions, community and staff meetings, extent of content coverage) (Protogerou et al., 2012). In other words, intervention appraisal research has focussed on dissecting the HBCIs: intervention techniques, design, and implementation procedures have been autopsied down to their minute particulars. Despite these intensive efforts, and while there is evidence for the effectiveness of certain HBCIs under certain conditions (e.g., Protogerou et al., 2020), overall, HBCI effects are small, variable, and not maintained long-term (Willmott & Rundle-Thiele, 2021).

HBCIs: Guideline focus

One key aspect of HBCIs – the healthcare guidelines embedded in them – do not typically undergo intensive scrutiny by intervention developers. Healthcare guidelines, or just "guidelines", are, "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Field & Lohr, 1990, p. 38). Guidelines address topics across the health care spectrum (i.e., illness prevention behaviours, diagnosis, and treatment plans), and are expected to enable consistent and effective health care practice, improve health outcomes, and inform health promotion and policy. Guidelines are developed by expert committees and professional societies, and in some places, by independent public bodies with the input of community stakeholders (Garbi, 2021). Most guidelines can be freely accessed through online repositories, such as the US National Guidelines Clearinghouse: https://www.ahrq.gov/prevention/guidelines/index.html and Guidelines: https://www.guidelines.co.uk/.

Health practitioners, researchers, policy-makers and laypeople alike, rely on guidelines to make decisions to promote health and prevent illness. HBCI developers will typically not generate their own guidelines but use extant guidelines to form the basis for their intervention, its rationale, and messaging (Eccles & Grimshaw, 2004). Then, through HBCI implementation and publication, extant guidelines are bolstered and perpetuated. However, the quality of guidelines has been found to be variable and often falling short of basic standards (Graham & Harrison, 2005; Florez et al., 2020), with claims that only about half of available guidelines are trustworthy (Iannone et al., 2016). Assessments of guideline methodological quality have often found guidelines to be of low quality, with small or no improvements in quality over time (Kung et al., 2012). Furthermore, evidence suggests that even well-developed guidelines become outdated quickly, with one out of five recommendations being out-of-date within three years of their release, and in need for revision (Garcia et al., 2014; Vernooij et al., 2014).

Reasons behind the development of substandard guidelines, and potential limitations and harms associated with them, have been proffered. Woolf et al. (1999) and Iannone et al. (2016) argue that the most serious limitation of extant guidelines is that they may be flawed—or flawed for some populations—for three reasons: (1) guidelines may not be evidence-based to begin with or based on imprecise, low-quality evidence; (2) guidelines may be heavily influenced by personal beliefs, preferences, clinical experience, and composition of guideline development committees; and (3) guidelines may be known to be sub-optimal for individuals but still recommended to minimize costs, serve certain societal needs, or protect the interests of groups (e.g., industries, funders). The adoption of flawed guidelines has the potential to cause harm, with the greatest potential harms for guideline recipients – that is, the public. Simply stated, flawed guidelines may result in individuals receiving ineffective or harmful care, or to individuals receiving blanket recommendations at the expense of personalized care (Guerra-Farfan et al., 2022). Health care practitioners, especially junior ones, tend to over-rely on guidelines without critically appraising their accuracy (Brichko et al., 2018), which could potentially result in inadvertently advocating/implementing flawed practices). Furthermore, medical malpractice litigation suits have been brought against health care practitioners who deviate from guidelines (Hyams et al., 1995; Mackey & Liang, 2011). So, while guidelines facilitate the implementation of standardized healthcare, they may also pose constraints to healthcare practitioner autonomy in choosing treatments beyond, or in addition to, standard care, and may contribute to defensive medicine practices (for a description of defensive medicine see Katz, 2019). Auditors, administrators, and managers are also likely to evaluate the quality of healthcare according to whether and to what degree practitioners have implemented (potentially flawed) guidelines to avoid malpractice claims (Zerbo et al., 2020). Furthermore, and more relevant to the present article, flawed guidelines can endanger HBCI-related research. For example, intervention research not complying with extant guidelines may be discouraged and may not get funded, thus halting scientific progress and perpetuating (flawed) guidelines. Embedding flawed guidelines in HBCIs can result in ineffective, wasteful, and potentially harmful interventions.

There is evidence to suggest that HBCIs may have been based on questionable guidelines and we offer the use of dietary fat guidelines as an illustration. In line with the national dietary fat guidelines introduced in 1977 and 1983 by the US and UK governments, respectively, dietary guidance for cardiometabolic health embedded in HBCIs has overwhelmingly and almost universally promoted the reduction of total and saturated fat intake (Estrada et al., 2022; Krist et al., 2020). Dietary fat guidelines were originally based on a theoretical link between fat consumption and coronary heart disease risk, and the goal of those guidelines was to reduce coronary heart disease by reducing overall fat consumption to 30% of total energy intake and saturated fat consumption to 10% of total energy intake (Cohen et al., 2015). Since their introduction, however, dietary fat guidelines have been questioned in terms of their credibility and health promoting effects (see Forouhi et al.'s, 2018 historical account of the origins of dietary fat guidelines and related controversies). Harcombe (2017) conducted a meta-review of four systematic reviews and where available, meta-analyses, to assess the evidence base of the dietary fat guidelines. The meta-review included evidence from randomized controlled trials (RCTs) and epidemiological studies available to the dietary guideline committees in 1977 (USA) and 1983 (UK); and evidence from RCTs and epidemiological studies available at the time of the meta-review to assess the evidence base in retrospect. Harcombe found that RCT and epidemiological evidence did not support the introduction or continuation of the fat consumption recommendations within the guidelines. In addition, the methodological quality of the reviewed evidence was judged to be so low that it could not be relied on had it provided support for the guidelines. Related, Astrup et al.'s (2020) state-of-the-art review of the effects of saturated fat consumption on health outcomes, risk factors, and mechanisms underlying cardiovascular and metabolic outcomes, found that the totality of the evidence does not support the guidelines' recommendations for limiting consumption of foods high in saturated fat. The review indicated that foods high in unprocessed saturated fat, specifically unprocessed red meat, full fat dairy, and dark chocolate are healthful, not associated with coronary heart disease risk, and need not be avoided.

As mentioned above, the uptake of flawed guidelines may lead to harms or unintended consequences for guideline recipients. Since the introduction of the dietary fat guidelines, fat consumption declined and carbohydrate consumption concomitantly increased, but without the anticipated decline in cardiovascular disease and other diet-related diseases (Dehghan et al., 2017). Some data present a (causal) link between the introduction of the dietary fat guidelines and concomitant increases in obesity and diabetes (e.g., DiNicolantonio, 2014; Hansen, 2013). Other data suggest health risks from avoiding healthy saturated fat consumption, given that saturated fats contain nutrients necessary for hormonal health, digestive health, and fat-soluble vitamin absorption (Gershuini, 2018), as well as for optimal brain function and mood (LaChance & Ramsey, 2018). Dietary fat guidelines have also led to fear, disgust, and avoidance of fat consumption, which has been found to be involved in the aetiology and worsened prognosis of eating disorders (Nguyen et al., 2019).

Recommendations for effective HBCIs

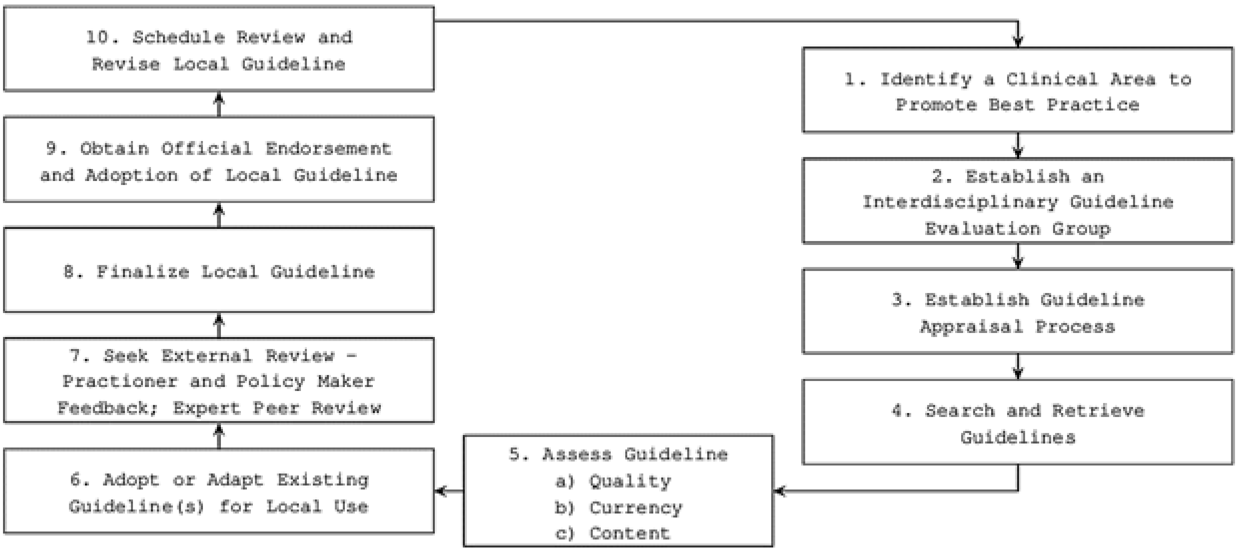
Considering the evidence suggesting that extant guidelines are of variable quality and applicability and in need of periodic revision (Garcia et al., 2014; Vernooij et al., 2014), we advocate implementing a guideline evaluation and adaptation process as an integral component of HBCIs, or as a research endeavour in its own right, alongside HBCIs. A guideline evaluation/adaptation process is particularly pertinent when a guideline is to be implemented in a context or population outside the one it was originally developed, as this process will facilitate targeting guidelines to local context/population, with increased likelihood of guideline acceptance, uptake, and adherence (Harrison et al., 2010).

While guideline appraisal can take various forms (e.g., reviewing the guideline content through evidence syntheses), we find that HBCIs may benefit from utilizing systematic guideline appraisal frameworks, such as the Practice Guidelines Evaluation and Adaptation Cycle (PGEAC, figure 1) (Graham et al., 2002; Graham & Harrison, 2005) - figure 1).We introduce the PGEAC process below and illustrate it using a hypothetical example with relevance to HBCIs: a research group decides to develop a dietary intervention to prevent or reduce depression in menopausal women. As part of designing the intervention, the research group decides to appraise *antidepressant foods* guidelines for menopausal women (by *antidepressant foods*, we refer to foods to prevent and promote recovery from depression).

1. Selecting a health/risk behaviour to improve using best evidence-based practice. Factors guiding behaviour selection include

Figure 1

The Practice Guidelines Evaluation and Adaptation Cycle (PGEAC: Graham & Harrison, 2005).



behaviour prevalence and associated burdens; concerns about adherence to behaviour and variations in healthcare; relevance and applicability of behaviour to target population/guidance recipients; the existence of relevant evidence-based guidelines; and the likelihood that extant guidelines may achieve what they are meant to.

Example. At this step the research team ascertains *whether* recommending foods to prevent or promote recovery from depression among menopausal women would be a good topic for a healthcare guideline. To answer this question, the research team collects information on depression incidence and prevalence in the population; burdens related to depression (e.g., financial costs, mortality, morbidity); variations in practice in recommending antidepressant foods; costs related to practice variations; the likelihood that a guideline for antidepressant foods for menopausal women would succeed in influencing practice; and the availability of extant evidence-based guidelines for antidepressant foods. Upon reviewing the evidence, the research group decides that having evidence-based recommendations for foods to prevent and promote recovery from depression among menopausal women is a valuable topic for a healthcare guideline and decides to set up a guideline evaluation group.

2. Setting up a guideline evaluation group. This would be an interdisciplinary group, comprising members with clinical content expertise, methodological expertise (e.g., in literature searches and guideline appraisal skills), HBCI developers, project managers, and members of the target population/guidance recipients.

Example. A panel is convened, involving psychologists, psychiatrists and other healthcare professionals dealing with depressed populations—ideally holding knowledge and expertise in applying dietary approaches to depression; dietitians—ideally holding knowledge relating to antidepressant foods; experts in menopause care; researchers with relevant methodological expertise; project management/admin staff; and other community stakeholders, such as patient groups, laypeople, and policymakers. Panel members are drawn from across geographical areas (e.g., cities, regions, countries) and across healthcare settings (e.g., public hospitals, private practice, community centres, industry, government). The panel is given the task of formulating a best practice antidepressant foods guideline for menopausal women and a name: the Menopause Moods Taskforce (MMT).

3. Establishing a guideline evaluation process. This step involves deciding on guideline selection criteria and an appraisal instrument. While there are at least 40 guideline appraisal instruments (Siering et al., 2013), the PGEAC framework recommends the Appraisal of Guidelines for REsearch and Evaluation instrument (AGREE: Terrace et al., 2003; Brouwers et al., 2010). The AGREE comprises a total of 23 Likert-type scale items evaluating six guideline domains, those being scope and purpose; stakeholder involvement; rigour of development; clarity of presentation; applicability; and editorial independence. Guidelines are given a standardized dimensional quality score ranging from 0 to 100. The AGREE is validated, translated in many languages, and comes with a user's manual.

Example. Members of the MMT with methodological expertise establish, and transparently document, criteria for selecting antidepressant foods guidelines to appraise. Selection criteria include guidelines that are international, peer-reviewed, written in English, published in the last 5 years, and targeting menopausal women. At this time, MMT members familiarize themselves with the guideline appraisal instrument.

4. Identifying the guidelines. This step involves a systematic search of all relevant guidelines using the selection criteria established in step 3.

Example. Members of the MMT with

methodological expertise apply the selection criteria established in step 3, to a systematic search of antidepressant foods guidelines. The search is conducted electronically on search engines such as PubMed, MEDLINE, Google Scholar, and the World Wide Web, using combined search terms of *practice guideline, clinical practice guideline, standard, statement, consensus, depression, mood, food, diet, nutrients, and menopause*. The systematic search failed to retrieve established antidepressant foods guidelines for menopausal women, though, and as a result, the MMT decides to expand the literature search to scholarly articles. The search retrieves scholarly articles with information on nutrients, supplements, and foods with antidepressant qualities for menopausal women, as well as recommended eating plans.

5. Appraising the guidelines. This step involves systematically appraising the overall quality of retrieved guidelines and the content of guideline recommendations. Using a validated guideline appraisal instrument like the AGREE offers many advantages, such as allowing the evaluation group to establish whether each guideline meets quality criteria; directing the groups' attention to methodological issues; ascertaining agreement/disagreement on raters' scores on the instrument; discussing and resolving disagreements; and calculating overall quality scores to rank guidelines according to quality criteria. As is the case in study quality appraisal (Greenhalgh & Brown, 2017), guideline appraisal is, ideally, conducted by at least two independent raters, to increase reliability assessment. The guideline appraisal process reduces the number of guidelines by revealing the ones that do not meet the minimum quality standards. Still, guideline appraisals by validated instruments are unlikely to provide enough information on the content of recommendations advocated by guidelines. Therefore, the next step would be to conduct a content analysis of the recommendations contained in the selected guidelines. This could entail one or two evaluation group members, ideally experienced in content analysis, to produce a table, also referred to as the *recommendation matrix* (e.g., Graham et al., 2002, p. 603), comparing the specific recommendations of the guidelines, and the level of evidence supporting each recommendation. The hierarchy/ pyramid of evidence (e.g., see Greenhalgh, 1997) may be used to ascertain the level of evidence in recommendations. The recommendation matrix would be used by the whole interdisciplinary group to discuss the content of the various dietary guidelines under consideration; identify whether the same recommendation is made by different guidelines or whether the recommendations differ; and identify recommendations linked to high levels of evidence or strong evidence. When guidelines contain recommendations supported by evidence of differing strengths, the group may want to select from the various guidelines the recommendations supported by the strongest evidence. In the absence of available guidelines, the evaluation group reviews the evidence from relevant studies, prioritizing those originating from higher levels of evidence (i.e., evidence syntheses and experimental studies).

Example. As the MMT found no established antidepressant foods guidelines for menopausal women, it content-analyses evidence from the retrieved studies. The outcome of the content analysis is a draft narrative and table with nutrients, foods, and supplements with antidepressant properties for menopausal women.

6. Adopting or adapting a guideline to embed in a HBCI. *Adopting* a guideline means choosing the best guideline and accepting all its recommendations "as is". *Adapting* a guideline means taking the best or most appropriate recommendations from more than one guideline and repackaging recommendations into a new guideline. Adaptation is particularly appropriate when guideline recommendations are not relevant or applicable to the target population, when logistics and available resources prohibit recommendation implementation, or when new evidence supports recommendation modification. In the absence of any formalized published guidelines, or in the presence of guidelines that are outdated and/or of very low quality, the evaluation group may develop recommendations *de novo*. Developing guidelines anew would involve prioritizing drawing information and guidance from high quality systematic reviews and experimental studies (Graham et al., 2002).

Example. Drawing from the content analysis, the MMT formulates its own guideline on antidepressant foods for menopausal women. The guideline advocates the consumption of foods that are the densest sources of nutrients found to be implicated in the prevention of and recovery from depression. The guideline ranks the foods in terms antidepressant nutrient density (most dense ranked first) and provides guidance for prioritizing foods based on nutrient bioavailability, that is, the proportion of a nutrient that is digested, absorbed, and metabolized. The guideline also provides background information on depression during the menopause.

7. Seeking external review of the guideline. At this step, the draft of guideline recommendations is disseminated to stakeholders outside the evaluation group for review and feedback. Obtaining this feedback has advantages, such as gauging practitioner and policymaker acceptance of the guideline and identifying potential obstacles to uptake.

Example. The MMT sends the antidepressant foods guideline draft to stakeholders for feedback. Stakeholders could include academic researchers in the fields of psychology, psychiatry, nutrition, and HBCI development; healthcare practitioners (e.g., physicians, nurses, nutritionists, menopause specialists); policymakers; and laypeople, including menopausal women. Stakeholders are asked to indicate the extent to which they approve the draft guideline, to state its strengths and weaknesses, and areas that might warrant improvement.

8. Finalizing the guideline. At this step, feedback by stakeholders and experts is reviewed and responded to. The guideline is modified where appropriate, and, potentially, pilot-tested. Modifications made to the guideline in response to feedback are documented, with reasons for the changes. Similarly, if the guideline is not modified despite feedback received, the rationale for this is documented.

Example. The MMT reviews feedback on the antidepressant foods guideline and makes changes based on the feedback. The MMT then pilot tests the draft guideline at the private practices of a nutritionist and a menopause specialist. Based on insights from the pilot testing, the MMT documents the process of guideline implementation and identifies factors that facilitate and inhibit implementation; evaluates the perceived utility and acceptability of the guideline; and further revises the guideline.

9. Adoption and implementation of the guideline. In this step, the proposed guideline is formally adopted and embedded in the HBCI. In other words, the guideline guides the formation of HBCI basis, rationale, messaging, and techniques. Furthermore, the guideline may be given “official status”, that is, endorsed by a relevant organization as policy.

Example. The research group develops a HBCI to promote and prevent depression among menopausal women, using the MMT guideline as its foundation. Furthermore, the MMT guideline receives endorsement by a national menopause specialists alliance and is situated on their website, as the recommended foods approach for menopausal women.

10. Scheduling a review and revision of the guideline. Based on guideline survival analyses (e.g., Garcia et al., 2014), healthcare recommendations become out-of-date in about three years, implying that the content/messaging of a HBCI may also become outdated in that time. Therefore, research and guideline evaluation groups may plan for a process of guideline revision and update or indicate a guideline "expiration date". Guideline revision may involve a small update based on a new piece of evidence or discussion with key stakeholders, or a larger update, involving undergoing the entire, or parts, of the evaluation cycle.

Example. At this step, the MMT schedules a review of the antidepressant foods guideline in three years. In this three year period, the MMT regularly monitors new evidence syntheses, randomized controlled trials, and other developments pertinent to the guideline to inform its review and revision.

For published examples of PGEAC implementation in healthcare see Mwangi et al.'s (2018) adaptation of clinical guidelines for diabetic retinopathy in Kenya, Wang et al.'s (2020) appraisal of the quality of nursing practice guidelines in China, and Trepanier et al.'s (2022) appraisal of psychology practice guidelines in Canada.

Conclusion

While healthcare guidelines have the potential to improve health outcomes, their beneficial effects are contingent upon a guideline development process that is methodologically rigorous and has considered the best available evidence. Even guidelines developed by expert committees and governmental bodies need to be scrutinized as it has been found that they may be flawed or out-of-date. Flawed guidelines may stand in the way of desired health behaviour change and pose potential harms to guideline recipients. HBCIs developers would therefore benefit from integrating a rigorous guideline appraisal process into their methods to adopt well developed guidelines that can be used with confidence. Alternatively, guideline appraisals could be conducted alongside HBCIs, as research projects in their own right. Appraisals of extant guidelines can inform clinical and HBCI decision-making on which guidelines are most appropriate for their context and population. Using a systematic and transparent framework for identifying, evaluating, adopting and adapting guidelines, or developing guidelines de novo, is critical as the decisions made based on guidelines affect patients, practitioners, and HBCI developers. Furthermore, a systematic guideline appraisal process like the one described in the present position paper raises awareness of evidence gaps relating to guidelines, fosters interdisciplinarity, and facilitates guideline adoption and implementation given buy-in from involved stakeholders.

References

Beard, E., West, R., Lorencatto, F., Gardner, B., Michie, S., Owens, L., & Shahab, L. (2019). What do cost-effective health behaviour-change interventions contain? A comparison of six domains. *PloS One, 14*(4), e0213983. https://doi.org/10.1371/journal.pone.0213983

Brichko, L., Mitra, B., & Cameron, P. (2018). When guidelines guide us to harm. *Emergency Medicine Australasia: EMA, 30*(6), 740-742. https://oi.org/10.1111/1742-6723.13189

Brouwers, M. C., Kho, M. E., Browman, G. P., Burgers, J. S., Cluzeau, F., Feder, G., ... & Makarski, J. (2010). Development of the AGREE II, part 1: Performance, usefulness and areas for improvement. *CMAJ, 182*(10), 1045-1052. https://doi.org/10.1503/cmaj.091714

Carey, R. N., Connell, L. E., Johnston, M., Rothman, A. J., De Bruin, M., Kelly, M. P., & Michie, S. (2019). Behavior change techniques and their mechanisms of action: A synthesis of links described in published intervention literature. *Annals of Behavioral Medicine, 53*(8), 693-707. https://doi.org/10.1093/abm/kay078

Cohen, E., Cragg, M., deFonseka, J., Hite, A., Rosenberg, M., & Zhou, B. (2015). Statistical review of US macronutrient consumption data, 1965–2011: Americans have been following dietary guidelines, coincident with the rise in obesity. *Nutrition, 31*(5), 727-732. https://doi.org/10.1016/j.nut.2015.02.007

Dehghan, M., Mente, A., Zhang, X., Swaminathan, S., Li, W., Mohan, V., ... & Amma, L. I. (2017). Associations of fats and carbohydrate intake with cardiovascular disease and mortality in 18 countries from five continents (PURE): A prospective cohort study. *The Lancet, 390*, 2050-2062. https://doi.org/10.1016/S0140-6736(17)32252-3

DiNicolantonio, J. J. (2014). The cardiometabolic consequences of replacing saturated fats with carbohydrates or Ω-6 polyunsaturated fats: Do the dietary guidelines have it wrong? *Open Heart, 1*(1), e000032. http://dx.doi.org/10.1136/openhrt-2013-000032

Eccles, M. P., & Grimshaw, J. M. (2004). Selecting, presenting and delivering clinical guidelines: Are there any "magic bullets"? *Medical Journal of Australia, 180*, S52-S54. https://doi.org/10.5694/j.1326-5377.2004.tb05946.x

Estrada, L. V., Solano, J., Turchioe, M. R., Cortes, Y. I., & Caceres, B. A. (2022). Comparative effectiveness of behavioral interventions for cardiovascular risk reduction in Latinos: A systematic review. *Journal of Cardiovascular Nursing, 37*(4), 324-340. http://doi:10.1097/JCN.0000000000000806

Field, M. J., & Lohr, K. N. (1990). *Clinical practice guidelines. Directions for a New Program, 1990*.http://www.guidelines-registry.cn/uploadfile/2016/0914/20160914112506974.pdf

Florez, I. D., Brouwers, M. C., Kerkvliet, K., Spithoff, K., Alonso-Coello, P., Burgers, J., ... & Straus, S. (2020). Assessment of the quality of recommendations from 161 clinical practice guidelines using the Appraisal of Guidelines for Research and Evaluation– Recommendations Excellence (AGREE-REX) instrument shows there is room for improvement. *Implementation Science, 15*(1), 1-8. https://doi.org/10.1186/s13012-020-01036-5

Forouhi, N. G., Krauss, R. M., Taubes, G., & Willett, W. (2018). Dietary fat and cardiometabolic health: Evidence, controversies, and consensus for guidance. *BMJ, 361*. https://doi.org/10.1136/bmj.k2139

Garbi, M. (2021). National Institute for Health and Care Excellence clinical guidelines development principles and processes. *Heart, 107*(12), 949-953. http://dx.doi.org/10.1136/heartjnl-2020-318661

García, L. M., Sanabria, A. J., Álvarez, E. G., Trujillo-Martín, M. M., Etxeandia-Ikobaltzeta, I., Kotzeva, A., ... & Alonso-Coello, P. (2014). The validity of recommendations from clinical guidelines: A survival analysis. *CMAJ, 186*(16), 1211-1219.https://doi.org/10.1503/cmaj.140547

Gershuni, V. M. (2018). Saturated fat: Part of a healthy diet. *Current Nutrition Reports, 7*(3), 85-96. https://doi.org/10.1007/s13668-018-0238-x

Graham, I. D., Harrison, M. B., Brouwers, M., Davies, B. L., & Dunn, S. (2002). Facilitating the use of evidence in practice: Evaluating and adapting clinical practice guidelines for local use by health care organizations. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 31*(5), 599-611. https://doi.org/10.1111/j.1552-6909.2002.tb00086.x

Graham, I. D., & Harrison, M. B. (2005). Evaluation and adaptation of clinical practice guidelines. *Evidence-based Nursing, 8*(3), 68-72. http://dx.doi.org/10.1136/ebn.8.3.68

Greenhalgh, T. (1997). How to read a paper: Getting your bearings (deciding what the paper is about). *BMJ, 315*(7102), 243-246. https://doi.org/10.1136/bmj.315.7102.243

Greenhalgh, J., & Brown, T. (2017). Quality assessment: Where do I begin. In A. Boland, M. G. Cherry & R. Dickson (Eds.). *Doing a systematic review: A student's guide* (2nd ed, pp. 107-131). Sage.

Guerra-Farfan, E., Garcia-Sanchez, Y., Jornet-Gibert, M., Nuñez, J. H., Balaguer-Castro, M., & Madden, K. (2022). Clinical practice guidelines: The good, the bad, and the ugly. *Injury*. Advance online publication. https://doi.org/10.1016/j.injury.2022.01.047

Hansen, A. (2013). Swedish health advisory body says too much carbohydrate, not fat, leads to obesity. *BMJ: British Medical Journal (Online), 347*. https://doi.org/10.1136/bmj.f6873

Harcombe, Z. (2017). Dietary fat guidelines have no evidence base: Where next for public health nutritional advice? *British Journal of Sports Medicine, 51*(10), 769-774. http://dx.doi.org/10.1136/bjsports-2016-096734

Harrison, M. B., Légaré, F., Graham, I. D., & Fervers, B. (2010). Adapting clinical practice guidelines to local context and assessing barriers to their use. *Canadian Medical Association Journal, 182*(2), E78-E84. https://doi.org/10.1503/cmaj.081232

Hyams, A. L., Brandenburg, J. A., Lipsitz, S. R., Shapiro, D. W., & Brennan, T. A. (1995).Practice guidelines and malpractice litigation: A two-way street. *Annals of Internal Medicine, 122*(6), 450-455. https://doi.org/10.7326/0003-4819-122-6-199503150-00008

Iannone, P., Montano, N., Minardi, M., Doyle, J., Cavagnaro, P., & Cartabellotta, A. (2016). Wrong guidelines: Why and how often they occur. *BMJ Evidence-Based Medicine*.http://dx.doi.org/10.1136/ebmed-2016-110606

LaChance, L. R., & Ramsey, D. (2018). Antidepressant foods: An evidence-based nutrient profiling system for depression. *World Journal of Psychiatry, 8*(3), 97. https://doi.org/10.5498/wjp.v8.i3.97

Katz, E. D. (2019). Defensive medicine: A case and review of its status and possible solutions. *Clinical Practice and Cases in Emergency Medicine, 3*(4), 329. https://doi.org/10.5811/cpcem.2019.9.43975

Krist, A. H., Davidson, K. W., Mangione, C. M., Barry, M. J., Cabana, M., Caughey, A. B.,... & US Preventive Services Task Force. (2020). Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: US Preventive Services Task Force recommendation statement. *JAMA, 324*(20), 2069-2075. https://doi:10.1001/jama.2020.21749

Kung, J., Miller, R. R., & Mackowiak, P. A. (2012). Failure of clinical practice guidelines to meet Institute of Medicine standards: Two more decades of little, if any, progress. *Archives of Internal Medicine, 172*(21), 1628-1633. https://doi:10.1001/2013.jamainternmed.56

Kvaavik, E., Batty, G. D., Ursin, G., Huxley, R., & Gale, C. R. (2010). Influence of individual and combined health behaviors on total and cause-specific mortality in men and women: The United Kingdom health and lifestyle survey. *Archives of Internal Medicine, 170*, 711-718. https://doi:10.1001/archinternmed.2010.76

Mackey, T. K., & Liang, B. A. (2011). The role of practice guidelines in medical malpractice litigation. *AMA Journal of Ethics, 13*(1), 36-41. https://doi.org/10.1001/virtualmentor.2011.13.1.hlaw1-1101

Michie, S., Richardson, M., Johnston, M., Abraham, C., Francis, J., Hardeman, W., ... & Wood, C. E. (2013). The behavior change technique taxonomy (v1) of 93 hierarchically clustered techniques: Building an international consensus for the reporting of behavior change interventions. *Annals of Behavioral Medicine, 46*(1), 81-95. https://doi.org/10.1007/s12160-013-9486-6

Mwangi, N., Gachago, M., Gichangi, M., Gichuhi, S., Githeko, K., Jalango, A., ... & Foster, A. (2018). Adapting clinical practice guidelines for diabetic retinopathy in Kenya: Process and outputs. *Implementation Science, 13*(1), 1-9. https://doi.org/10.1186/s13012-018-0773-2

Nguyen, N., Dow, M., Woodside, B., German, J. B., Quehenberger, O., & Shih, P. A. B. (2019). Food-intake normalization of dysregulated fatty acids in women with anorexia nervosa. *Nutrients, 11*(9), 2208. https://doi.org/10.3390/nu11092208

Pope, J. P., Pelletier, L., & Guertin, C. (2018). Starting off on the best foot: A review of message framing and message tailoring, and recommendations for the comprehensive messaging strategy for sustained behavior change. *Health Communication, 33*(9), 1068-1077. https://doi.org/10.1080/10410236.2017.1331305

Presseau, J., Byrne-Davis, L. M., Hotham, S., Lorencatto, F., Potthoff, S., Atkinson, L., ... & Byrne, M. (2022). Enhancing the translation of health behaviour change research into practice: A selective conceptual review of the synergy between implementation science and health psychology. *Health Psychology Review, 16*(1), 22-49. https://doi.org/10.1080/17437199.2020.1866638

Protogerou, C., Flisher, A. J., & Morojele, N. K. (2012). Evaluated interventions to prevent substance abuse among young South Africans. In G. Ellis, D. Stein, E. Meintjies & K.Thomas (Eds.), Substance use and abuse in South Africa. Insights from brain and behavioural sciences. Cape Town: UCT Press.

Protogerou, C., & Johnson, B.T. (2014). Factors underlying the success of behavioral HIV-prevention interventions for adolescents: A meta-review. *AIDS and Behavior, 18*, 1847-1863. https://doi.org/10.1007/s10461-014-0807-y

Protogerou, C., Johnson, B.T., & Hagger, M. S. (2018). An integrated model of condom use in sub-Saharan African youth: A meta-analysis. *Health Psychology, 37*, 586-602. https://doi.org/10.1037/hea0000604

Protogerou, C., McHugh, R. K., & Johnson, B. T. (2020). How best to reduce unhealthy risk-taking behaviours? A meta-review of evidence syntheses of interventions using self-regulation principles. *Health Psychology Review, 14*(1), 86-115. https://doi.org/10.1080/17437199.2019.1707104

Siering, U., Eikermann, M., Hausner, E., Hoffmann-Eßer, W., & Neugebauer, E. A. (2013). Appraisal tools for clinical practice guidelines: A systematic review. *PloS One, 8*(12), e82915. https://doi.org/10.1371/journal.pone.0082915

Terrace, L. (2003). Development and validation of an international appraisal instrument for assessing the quality of clinical practice guidelines: The AGREE project. *BMJ Quality and Safety, 12*(1), 18-23. http://dx.doi.org/10.1136/qhc.12.1.18

Trepanier, L., Hébert, C., Stamoulos, C., Reyes, A., MacIntosh, H., Beauchamp, S., ... & Drapeau, M. (2022). The quality of four psychology practice guidelines using the Appraisal of Guidelines for Research and Evaluation (AGREE) II. *Journal of Evaluation in Clinical Practice*, 1-9. https://doi.org/10.1111/jep.13699

Vernooij, R. W., Sanabria, A. J., Solà, I., Alonso-Coello, P., & Martínez García, L. (2014). Guidance for updating clinical practice guidelines: A systematic review of methodological handbooks. *Implementation Science, 9*(1), 1-9. https://doi.org/10.1186/1748-5908-9-3

Wang, Y., Yu, S., Wang, L., Liang, D., Shen, Q., Xue, H., & Jin, Y. (2020). The methodology for developing nursing clinical practice guidelines over recent decades in China: A critical appraisal using AGREE II. *Journal of Nursing Management, 28*(4), 976-997. https://doi.org/10.1111/jonm.13007

Willmott, T., & Rundle-Thiele, S. (2021). Are we speaking the same language? Call for action to improve theory application and reporting in behaviour change research. *BMC Public Health, 21*(1), 1-8. https://doi.org/10.1186/s12889-021-10541-1

Zerbo, S., Malta, G., & Argo, A. (2020). Guidelines and current assessment of health care responsibility in Italy. *Risk Management and Healthcare Policy, 13*, 183.https://doi.org/10.2147/RMHP.S238353

Cleo Protogerou
Institute of Health and Wellbeing,
University of Suffolk, UK and
Department of Psychology, University
of Crete, Greece.
cleoprotogerou@uoc.gr

Valerie F. Gladwell
Institute of Health and Wellbeing,
University of Suffolk, UK
v.gladwell@uos.ac.uk

Introducing the new EHPS Executive Committee Members 2022-2024

President: Wendy Hardeman (Netherlands/UK)

I am Professor of Behavioural Science at the School of Health Sciences, University of East Anglia (UK). I lead the research theme 'Behaviour Inequalities and Health' at the Norwich Institute of Healthy Ageing, working as part of a multi-agency partnership to address health inequalities through behaviour change. My research programme focuses on the development and evaluation of theory- and evidence-based behaviour change interventions, targeting a wide range of behaviours including physical activity, eating behaviours, medication taking and delivery of evidence-based care. I co-authored the Behaviour Change Technique Taxonomy v1 and the UK Medical Research Council guidance on process evaluation of complex interventions.

The EHPS has been a continuous and positive presence throughout my academic career. I have met many good friends and future collaborators ever since my first EHPS conference (Florence, 1999). I chaired the Scientific Committee of the EHPS/British Psychological Society Division of Health Psychology 2016 conference in Aberdeen, Scotland. As President-Elect I have had the privilege and pleasure of chairing the EHPS Mentoring Task and Finish Group which has developed the EHPS Ari Haukkala Mentoring Programme. A pilot of the mentoring programme will launch soon.

I am privileged to be the President of the EHPS for the next two years. My priorities are to facilitate and strengthen connections and collaborations between EHPS members, especially our PhD students and early career researchers, after a challenging few years; enable decision-making about our future conferences; facilitate initiatives to increase reach and impact of the EHPS in addressing major challenges such as climate change and health inequalities; and strengthen collaboration with other international organisations and societies.

President Elect: David French (UK)

I have been Professor of Health Psychology since 2009, and have worked at the University of Manchester for the past 10 years. My main research interest is in developing and evaluations interventions with reach to promote health and wellbeing. Current projects include developing and evaluating nationally implemented interventions, including the NHS Diabetes Prevention Programme and NHS Breast Screening Programme. Notable contributions to health psychology and multidisciplinary health research include:

- •Published over 200 articles in peer-reviewed journals, including eight in the BMJ, and many others in Health Psychology, Annals of Behavioral Medicine, etc.
- •Research funding of over €80 million from bodies including European Commission, MRC and NIHR.

- British Psychological Society official publication: British Journal of Health Psychology Editor for 5 years (2013-2017) with Prof Alison Wearden.
- MRC/ NIHR guidance on Development and Evaluation of Complex Interventions (third edition) Scientific Advisory Group member and author.
- Research Excellence Framework (REF) 2021, sub-panel 2: Public Health, Health Services and Primary Care, Panel Member.
- Served on several research funding panels, including MRC Methodology Research Panel, NIHR Public Health Research, NIHR Programme Grants for Applied Research.

I have been a regular contributor to the EHPS since attending my first conference, in Dublin in 1996. Since then, I have been involved with the EHPS in a number of roles:

- One of the four founding members of the CREATE (Collaborative REsearch And Training in the EHPS) initiative: www.ehps.net/create. I was jointly responsible for organizing the first three annual training workshops adjacent to the EHPS Annual Conference (1999, 2000, 2001), before handing over to new organizers. The current organizers are now preparing the twenty-fourth workshop to be held in Bremen.
- UK National Delegate to the EHPS (2000-2004)
- Member of the executive committee of the EHPS, as National Delegates Officer (2004-2006).
- EHPS liaison officer for the 2007 conference that was held in Maastricht.
- Conference Scientific Committee Chair for joint European Health Psychology Society (EHPS) and the British Psychological Society Division of Health Psychology annual conference in 2008 (Bath).
- EHPS Conference Scientific Committee member in 2007, 2009, 2011 and 2018.
- EHPS Conference International Programme Committee member and track chair on seven occasions (2005, 2006, 2010, 2011, 2013, 2014, 2020).
- EHPS journal, Psychology and Health Associate Editor (Dec 2009 to Dec 2012)
- Elected Fellow of the European Health Psychology Society in 2012.
- Member of EHPS Fellowship committee since 2021.

My focus over the next few years will be on bringing researchers and practitioners across Europe together after not meeting in person over recent years. I think it is timely to focus on helping earlier career people feel part of a supportive and facilitative international community, as there may be a generation of people who have not benefitted from attending EHPS conferences in person since 2019. More concretely, over the next two years, I will aim to support CREATE and SYNERGY in their endeavours, review the current conference provision, and run the pilot mentoring scheme.

Past President: Evangelos Karademas (Greece)

I am a Professor of Clinical Health Psychology at the Department of Psychology, University of Crete, Greece. For more than a decade, I served as the Head of the Counselling Center for Students at the University of Crete. I also served as Head of the Department of Psychology, University of Crete for two years. I currently collaborate with the Foundation for Research and Technology – Hellas (FORTH), the University of Crete Medical School, and the Faculty of Nursing at the University of Athens. I am also actively involved in the activities of local associations for the support of patients suffering from cancer.

I have been a member of the European Health Psychology Society since 2002. I have helped in the organization of several EHPS conferences as a member of the Scientific Committee or as a Track Chair, and I was the Chair of the Organizing Committee of the 25th EHPS Conference in Crete. In 2018, I was elected an Honorary Fellow of the Society. My research interests include patient adaptation to chronic illness, the role of stress and related factors in health and illness, individual differences in health, self-regulation and dyadic regulation.

I am deeply honoured to have served as the President of EHPS during the past two years. My priorities for the next two years, as past president, will be to pass on all the experience I gained as president of our Society to the new president and the president-elect, facilitate the necessary decision making regarding the format of our future conferences, and also promote the development of actions that will enhance the impact and the role of the EHPS.

Secretary: Noa Vilchinsky (Israel)

My name is Noa Vilchinsky. I am an Associate Professor in the Department of Psychology at Bar-Ilan University, Israel, and the Head of the Psycho-cardiology Research Lab. I am also a certified rehabilitation psychologist and for many years I have been working with patients coping with cardiac diseases. My research focuses mainly on the following subjects: Psycho-cardiology, caregiving, and dyadic coping. I am eager to understand how patients' and caregivers' personality characteristics, spousal relationships, and cultural backgrounds contribute to patients' and partners' outcomes.

EHPS has played a major role in my career as well as in my life in general. I have attended the annual conferences since 2006, discovering a vast world of knowledge, first-rate science, and friendship. Many of my international cooperation endeavors were made possible thanks to the EHPS network. In 2014, I was fortunate to receive (together with Prof. Tracey Revenson, USA and Prof. Val Morrison, UK) the EHPS networking grant. This grant paved the way for the publication of our book: Revenson, T.A., Griva, K., Luszczynska, A., Morrison, V. Panagopoulu, E., Vilchinsky, N & Hagedoorn, M. (2016). Caregiving in the Illness Context. Hampshire, England: Wiley. In 2018, Prof. Morrison and I, together with two other EHPS members, Prof. Mariet Hagedoorn and Prof. Robert Sanderman, won the prestigious HORIZON 20/20 grant for our CAREGIVING project.

Wishing to "pay it forward," and to be a contributor to EHPS myself, I became more and more active in presenting, chairing, track chairing, abstract reading and participating in award committees. In 2016, I was nominated to be Israel's national delegate, and I also took on the role of Hebrew-language editor for the EHPS PHP blog. In 2017, I served as the co-chair of the Scientific Committee for the 31st EHPS annual conference held in Padua, Italy.

My first goal as the secretary was to update and reshape the society's website which was archaic in design and did not support the society's growth and richness of activity. After working on the website for a year together with the dedicated Dusan from Easy Conferences, and with the enormous help from the EC members, I am happy to invite all EHPS members to our updated beautiful website. I encourage you to send me materials you wish to upload and inform me about any error or problem you detect (noa.vilchinsky@biu.ac.il).

Next on my agenda as the secretary is to strengthen the EHPS collaboration with other relevant societies, and especially with societies of clinicians who could greatly benefit from attending the EHPS conferences and learning about state-of the-art evidence-based practice.

Treasurer: Michael Kilb (Germany)

I completed my Ph.D. at the Health Psychology Lab of the University of Mannheim (Germany). In my dissertation, I examined the influence of social media on health behaviors, especially eating behavior. I also examined how social media could be used for health behavior interventions. Currently, I am a postdoctoral researcher at the Institute of Child Nutrition of the Max Rubner-Institut (MRI), Federal Research Institute for Food and Agriculture in Germany. At the MRI, my research focuses on the awareness and applicability of the current German food-based dietary guidelines for children and adolescents. Furthermore, I am interested in long-term health behavior change and habit formation, digital health, and experience sampling and multilevel modeling methodology.

In my teaching, I covered the topics of health behavior interventions (from theory to practice), obesity etiology, prevention and intervention, prevention of mental disorders, and biological foundations of health behaviors. I am also contributing to science communication in health psychology (in my web blog and as a member of the blog team of In-Mind.org). Throughout my research, I worked with experimental methods and intensive longitudinal data (experience sampling and daily diaries).

I mainly experienced the EHPS from the view of a participant in events and special interest groups organized by the society (EHPS conferences, CREATE workshops, digital health, and computer tailoring SIG). I am also a member of the International Society for Behavioral Nutrition and Physical Activity and the national health psychology group of the German Psychological Association. However, the EHPS has a special and unique role in connecting researchers in health psychology within Europe and worldwide.

I enjoy being part of this inspiring society, and I want to give something back by serving as a treasurer for the EHPS. Thereby, I aim to support the society in reaching its important tasks (e.g., organizing conferences and workshops) and expand its role as a leading society for health psychology researchers. I am very happy to further support the society in achieving democratic decisions that make the society grow and become even better in the long term by serving as an executive committee member. In particular, I would like to incorporate the perspective and needs of early career researchers into the decision-making processes of the executive committee.

Membership Officer: Julia Allan (UK)

I am a Chartered Psychologist. HCPC Registered Health Psychologist and am currently a Senior Lecturer in Health Psychology at the University of Aberdeen in Scotland. My research focuses on health behaviour and behaviour change, and in particular on; (1) patterns in health behaviours and decisions over time (e.g. food choice, stress, fatigue, clinical decision making etc.); (2) behavioural control (e.g. how people stick to diets; adhere to guidelines etc.), and (3) how systems and environments can be modified to change behavior and improve health outcomes.

I am a full member of the EHPS and regularly attend and present at the annual conference. I was Chair of the British Psychological Society's Division of Health Psychology Scotland (DHPS) from 2018-20 and remain on the committee as an ordinary member, working with colleagues to further develop health psychology training in Scotland and to support the transition of health psychology graduates into the workplace. I have a keen interest in raising the profile of Health Psychology as a discipline and have worked with policy makers, healthcare organisations, third sector organisations and other bodies (e.g. Food Standards Scotland) to integrate Health Psychology evidence and practice into their work.

Within the EHPS EC, I have responsibility for membership and am working with colleagues to develop resources to support better engagement between members and policy makers.

Grants Officer: Angelos Kassianos (Cyprus)

I completed my PhD in Health Psychology at the University of Surrey (UK) in 2014. I am currently a Lecturer in Health Psychology at the Cyprus University of Technology, an Honorary Senior Fellow at University College London (UCL), Department of Applied Health Research and a Visiting Tutor at the University of Cambridge Pre-Med course. I have previously worked as a researcher in the UK (University of Cambridge, Imperial College London etc.) and the US (Harvard Medical School as Fulbright Visiting Scholar in 2015). My research interests include the behavioral science contribution to cancer prevention, early diagnosis and the development and evaluation of theoretically informed digital interventions for health behaviour change and collection of patient-reported outcomes.

During the COVID-19 pandemic I have led or co-led several studies to understand the experience of the illness, the contributing factors to self-protective measures and hesitancy to vaccination, including the project COVID-19 IMPACT in which we collected data from more than 10,000 people internationally.

I currently lead or co-lead several research projects funded by the UK Policy Research Unit, Cancer Research UK, the Cyprus Research and Innovation Foundation and the Union for International Cancer Control. At the same time my teaching is focused on mixed research methods, statistics, inequalities in healthcare, psychometrics and health psychology theories and methods.

I have been a member of EHPS since 2012 and have participated in all conferences since then. I have been an active member of the EHPS-UN Sub-Committee from 2012 to 2017 following my internship at the World Health Organization (WHO). I have been the EHPS National Delegate (ND) of Cyprus since 2015. In this role, I have collaborated with other NDs to set-up a task force commissioned by the EC to examine how health psychology is practiced in EHPS countries and beyond. The results of this work have been presented in roundtables in three EHPS Conferences (2016-2018) and in a Special Issue of the European Health Psychologist on January 2018 where I served as a Guest Co-Editor. We are currently re-examining the competencies of Health Psychologists in Europe together with the European Federation of Psychologists' Associations (EFPA) where I serve as a Board Member of the Prevention and Intervention Board. I have received the 2018 EHPS Early Career Award and I act as National Editor for the Practical Health Psychology blog. In 2017, I received the Young Transatlantic Innovation Leaders Initiative (YTILI) Fellowship from the US Department of State and in 2020, I received the Young Researcher Award from the Cyprus Research and Innovation Foundation.

My priorities for the next 2 years as Grants Officer of the EHPS EC are to (a) contribute to the EC goals, tasks and activities with an emphasis on transparency and inclusion (b) widen the participation of EHPS members on the grant activities; (c) collect feedback on expanding the current grants and tailoring to the needs of the EHPS members and especially the early career members and under-represented groups and (d) support the work and the role of the Special Interest Groups (SIGs) with an emphasis to extend their impact, visibility and activities. Also, milestones like the COVID-19 pandemic, advances in chronic conditions' longevity and climate change, bring major challenges and I believe that we need to be collectively responding. Our role needs to be expanded considering these challenges at the same time as our methods becoming more robust and transparent.

National Delegates Officer: Dominika Kwasnicka (Poland/ Australia)

I am a Senior Research Fellow at University of Melbourne in Australia and at SWPS University of Social Sciences and Humanities in Poland. The overarching aim of my scientific work is to advance psychological theory of behaviour-change maintenance and to design, implement, and scale behavioural interventions to improve population health. My research makes three key contributions to the field of Health Psychology, by: (1) Integrating theories of behaviour-change maintenance, investigating key predictors of maintained health behaviour-change; (2) Testing and advancing these theoretical predictors in systematically-developed studies and evidence-based interventions focusing on diet, physical activity, and weight loss maintenance; (3) Contributing to the development of novel research methods employing upcoming designs such as within-person studies using emerging technologies.

I collaborate with world leading researchers, including academic colleagues from the UK, the Netherlands, Finland, the US, Portugal, Poland, France, Germany, and Australia. I have secured funding and delivered international research projects (e.g., weight loss maintenance RCT in Poland, funded by European Union structural funds) and co-authored several collaborative publications, presented my work at national and international presentations and invited international talks. I also teach within-person methods and provide consultancy to fitness agencies and digital health organisations (e.g., Mental Health Commission, Western Australia).

Since 2010, I am an active member of EHPS. I received the Stan Maes Early Career Researcher Award (2019) and the Herman Schaalma Award (2016) acknowledging my Health Psychology research and contribution to the EHPS. I am a Head Editor of the Practical Health Psychology Blog (www.practicalhealthpsychology.com), an online international publication informing practice, translated to 30 languages. I am also one of the co-founders of the Open Digital Health, organisation affiliated with the EHPS, aiming to promote dissemination of digital health tools following the principles of openness and reuse of existing digital resources (www.opendigitalhealth.org). I was a Liaison Officer and grant reviewer and a Chair for EHPS Synergy. Previously, I was also a member of EHPS eCourses organising committee and CREATE Organising Board. I served on editorial boards of the European Health Psychologist, and Health Psychology Bulletin. I am also an active and regular participant of EHPS conferences and Synergy meetings; I presented my work at EHPS conferences and have served as session chair for oral and poster presentations. I served as a member of EHPS Scientific Committee twice. I have co-delivered pre-conference workshops on N-of-1 design and Synergy meeting on the topic of Open Digital health, and led on a collaborative publications resulting from these meetings. I am looking forward to continuing to contribute to the dynamic work of the EHPS, providing enthusiasm and support to the Society Executive Committee activities.

EHP Editorial Board

EHPS Executive Committee (2020-2022)