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Special Issue on Spotlight on MSc Research

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editorial

Spotlight on MSc Research

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Happily, some MSc health psychology theses make their way to good journals and receive the attention that they deserve. However, a significant number of good quality research theses are 'left on the shelf' and do not manage to find an audience beyond the walls of the university. The reasons for this are various, and can include a lack of time due to starting a new job and/or a lack of motivation to revisit a time-consuming task. It with this in mind the EHP Bulletin aims to provide a spotlight on worthy MSc research that deserves more attention. To make it easy, we are asking individuals to submit a 1500 synopsis of their MSc research. So, if you have recently finished your MSc would like to disseminate your considerable effort, contact us. Congruently, if you supervise MSc work and have identified some 'diamonds in the rough' that definitely deserve more attention, please nudge the MSc student to submit a manuscript.

Hopefully, this is the first in a series and we encourage all EHPS members to consider pointing high quality research in our direction, so as to showcase the important work that is conducted at this level.

This first issue includes four articles. Andrew Sentoogo Ssemata and Rachel Shaw provide a narrative analysis of the experiences of first year university international students' fruit and vegetable consumption. Their paper highlights how eating Fruits and vegetables can became an exception rather than the norm influenced by the easy accessibility of fast-food or ready meals perceived as tastier, cheaper, convenient and quicker, reflecting the negative impact of the 'McDonaldization' of university life. In the second paper, Catherine Grimley and Claire Farrow compare the approaches of parents and nursing staff to the eating behaviours of pre-school children. Interestingly, parents describe their children as displaying significantly higher levels of food avoidance and food approach behaviours at home compared to the reports from nursery staff (who use modelling behaviours more frequently). In third paper, Sarah-Louise Tarpey, Line Caes and Caroline Heary explore the experiences of Irish primary school personnel in supporting students with chronic pain. Their interviews highlight how despite not always being the person to provide one-to-one support, teachers are integrally involved in the child's support plan. Ultimately, teachers believe pain should be managed in school and that many of the support strategies they currently implement and wish to implement are centred on helping the child remain in school while experiencing pain.

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original article

Spotlight on MSc Research

Supporting Children with Chronic Pain in School: Understanding Teachers' Experiences of Pain in the Classroom

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Chronic pain is a common experience for children with the median international prevalence rate ranging from 11% to 38% (King et al., 2011). Within an Irish context, approximately 10% of primary school children suffer from chronic pain (O'Higgins et al., 2015). Headache, abdominal and musculoskeletal pain are the most commonly reported types of paediatric chronic pain (King et al., 2011). However, children often report pain in multiple sites (Perquin, 2000). Children spend a majority of their waking hours in school and for those with chronic pain, attendance, academic achievement, peer relationships and their perceived competence in these domains can be negatively impacted by the experience of persistent pain (Dick & Riddell, 2010; Gorodzinsky, Hainsworth & Weisman, 2011).

Previous studies have found teachers face many challenges in supporting adolescents with chronic pain including high absenteeism, students' experience of symptoms and impairments, balancing the needs of all students and working with parents (Mukherjee, Lightfoot & Sloper, 2000; Logan & Curran, 2005).

To date, research has concentrated on the adolescent population and failed to investigate the experience of supporting younger children with chronic pain in school. It is reasonable to assume that younger children may rely more on teachers for support due to their age and developmental capacities. Accordingly, the aim of this research is to explore the experiences of Irish primary school personnel in supporting students with chronic pain.

Methods

Participants

Eight primary school staff from seven schools agreed to participate. All participants had experience of teaching at least one child with chronic pain, with children's age ranging from five to twelve years. Further details on participant characteristics and their students with pain can be seen in Table 1.

Design

This study utilised an inductive qualitative design consisting of open-ended individual interviews with primary school teaching staff.

Procedure

The study was approved by the University Ethics Committee. Participants were recruited from local schools and schools which participated in the PRIME-C study (O'Higgins et al., 2015). Schools were provided with the information sheet and research team contact details. Teachers interested in participating contacted the researcher directly. Interviews took place in an interview room at the University or at the participants' school. The researcher introduced the study and answered any

Table 1

Demographic Characteristics of Participants (n = 8)

	Frequency	Years
Sex		
Male	2	
Female	6	
Age		
Range		26-48
Mean		35.38
Teaching Role		
Teaching principal	1	
Mainstream class teacher	5	
Special Needs Assistant (SNA)	2	
Teaching experience		
Range		7-25
Mean		11.63
School Location		
Rural	4	
Urban	4	
Type of pain experienced by student(s)		
Musculoskeletal	5	
Abdominal	3	
Headache	3	
Multiple sites	1	
Diagnosis		
Yes	5	
No	3	
Physical Disability		
Yes	3	
No	5	

questions before the participant signed the consent form and completed a demographic form. All interviews were audio recorded using a digital voice recorder to facilitate transcription. Each interview lasted approximately 38 minutes (ranged from 25 to 51 minutes). SPSS software was used to statistically analyse participants' demographic information. Interviews were transcribed and inputted into NVivo (2012) software for qualitative analysis. Analysis followed the stages of thematic analysis as outlined by Braun and Clarke (2006). Thematic analysis was chosen as it provides a well-defined procedure of analysis while maintaining the flexibility to investigate a broad research question. Once analysis was completed, participants were emailed a debriefing sheet providing an overview of the findings.

Results

Theme 1: Power of diagnosis

School personnel discussed the powerful influence a diagnosis had on whether a child was supported or not. Unanimously, school personnel saw diagnosis as a catalyst to supportive engagement with students with chronic pain. T1 *"once that's in place there can be suggested protocol to follow."*

In the presence of a diagnosis, teachers felt they no longer had to question the motive of the child's pain. T4 *"I would say a diagnosis kind of does make you a bit more aware … you can see where it's coming from, she's not putting it on".* When pain was undiagnosed, school staff described judging the authenticity of their students' pain. T1 *"you're making a call yourself on whether this child is faking it or that they're genuinely sick and they're experiencing pain."*

The classroom experience of teachers whose students had a physical disability differed profoundly from those teaching children without a physical disability. Children with a physical disability received more support in general and specifically for their pain from the school and external organisations. Staff were prepared to anticipate and accommodate the potential needs of children with physical disabilities. T6 *"They [disability organisation] were able to tell us what he was able in and what he needed help with."*

Theme 2: Role of school staff in supporting a child's pain

School personnel had a strong sense of their own role, their colleagues' roles and the role of the school system in supporting children with pain at school. Class teachers saw themselves at the centre of the child's support system: accessing and delegating academic and emotional support and communicating the child's needs to school personnel and parents. Support staff focused on pain relief, enhancing the child's quality of school life and maximising physical and psychosocial functioning. Their more personal relationship with the child helped overcome limitations to the level of support teachers can provide to children with chronic pain. T8 *"There's no possible way a teacher can cater for a child like that with other children on top."* School personnel placed great importance on their role in not only supporting the child's physical experience of pain but also the emotional and social consequences of chronic pain. *"To know that there's somebody there that she can ask for help is a good thing. I think it has affected her positively, even now she is a lot more outgoing and she'll participate more."*

Theme 3: Supporting schools to support children with pain.

Subtheme 1: Pain can be treated in school, provided that teachers are supported.

High class numbers, curriculum overload and space were some of the challenges teachers faced as they tried to balance the needs of the child with pain and their peers. School personnel identified SNAs' (Special Needs Assistant) as key to overcoming these limitations by supporting both students with pain and teachers. The presence of another staff member in class creates opportunities for meaningful engagement with the student with chronic pain.

Teachers reported absenteeism as an issue for children with chronic pain; they did not believe going home was a practical or effective support strategy. They spoke about the consequences missing school has for the child's education and friendships and for working parents. While they recognised the need for the long-term management rather than acute treatment of pain in chronic situations, school staff are not practically supported to keep a child with pain in school. T1 *"you're not getting to the root of it, it's not a fix to be sending the child home every time … if they have got a chronic illness there has to be some other way of really managing it, maybe in school."*

In line with this, school staff placed importance on having congruence between the pain support provided at home and at school. T1 *"If the child has chronic pain at home there has to be something the parents can do for them, and if the teacher is doing the same thing in class all the while helping them stay where they are."*

Subtheme 2: Pain needs to be given more credence in the provision of school resources.

School personnel see the needs of the classroom changing with mainstream schools becoming more inclusive. However, they are not being provided with the training or resources to cater for such needs, like chronic pain. Even with a diagnosis, support allocations within Irish primary schools do not cater for children with pain. School personnel believe change must begin at a government level. T8 *"That directive needs to come from the Department (of Education and Skills). If it doesn't come from the top it's not going to happen at the next level down."*

Subtheme 3: Support strategies.

School staff emphasized that an understanding of pain is not enough for the provision of support; teachers need practical strategies they can implement in the classroom. T1 *"there's all these reports about symptoms and that's all fine but what are you going to do when a child comes up to you? You can come up with loads of things yourself but are you doing the right thing?"*

Participants compensated for the lack of training and resources by creating their own strategies for supporting students' pain. These strategies ranged from creating protocol for the child's care to including stretches for muscle pain relief in Physical Education lessons. Suggested strategies for supporting teachers with students with pain in the future included training, guidance from medical professionals, classroom materials specific to coping with chronic pain and inclusive curriculum.

Furthermore, school staff believed that having the skills to support their students would not only benefit students but also themselves by giving them confidence to provide support. T1 *"As a teacher it would give you confidence to say ok now this is what we're going to do… you can step in the first time they complain, you know what to do. You're not going to have to let it go to such a point where you're like all we can do now is send you home."*

Discussion

This study provides insight into the lived experience of paediatric chronic pain in the classroom from the perspective of primary school personnel. Many of the challenges faced by primary school personnel in this study are echoed in studies with school personnel who teach adolescents with chronic pain (Logan & Curran, 2005), highlighting the consistency of the challenges across development.

Our study adds to previous findings (Mukherjee et al., 2010) with the presence of a diagnosis seen as a reassurance for teachers as well as a crucial starting point for support. However, although diagnosis was seen as helpful, school personnel expressed frustration as the resources available within the Irish educational system do not apply to chronic pain diagnoses.

At a school level, staff identified support from colleagues as fundamental to meeting a child's needs. Despite not always being the person to provide one-to-one support, teachers are integrally involved in the child's support plan. Nabors and colleagues (2008) suggested that to meet the needs of children with health conditions, schools should have a designated professional responsible for supporting teachers, and who serves as a liaison between the child, parents and medical team. Results from this study imply that such a system could be beneficial in overcoming the challenges identified by school personnel.

A limitation of the present study is the small sample size. Further research is needed with a larger sample to allow for more generalizable findings that can be utilised for the development of interventions or support recommendations. Due to the presence of external supports for children with physical disabilities, it would also be worth considering whether there are differences between the experiences of teachers who teach children with chronic pain with and without and associated physical disability.

An important contribution of this research to the paediatric pain literature is the exploration of chronic pain in the primary level classroom. As indicated by the current study, younger children rely heavily on their teachers for support. Incorporating the perspectives of key gatekeepers such as teachers in children's wellbeing is essential for the physical, emotional and functional consequences of pain to be fully addressed. If the psychosocial consequences of pain are addressed at an earlier age, the impact on a young person's

psychosocial functioning can be minimised during the important developmental stage of adolescence.

In sum, our findings show that teachers believe pain should be managed in school and that many of the support strategies they currently implement and wish to implement are centred on helping the child remain in school while experiencing pain. By providing more formalised support for teachers, school absence due to chronic pain could be reduced and children's school experience improved.

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original article

Spotlight on MSc Research

Are children really less fussy with food at nursery compared to at home?

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Introduction

Fussy eating is a common concern in childhood, affecting between 27-50% of young children (Benjasuwantep, Chaithirayanon, & Eiamudomkan, 2013; Carruth, Ziegler, Gordon, & Barr, 2004). At the same time over one fifth children are overweight or obese by the time they reach school age (National Statistics, 2015). Problems with child eating behavior, such as fussy eating or childhood overweight, are a significant source of concern and stress for many parents but also present health issues for many children. For example, food fussiness is associated with poor growth (Xue et al., 2015) and later eating disorders (Marchi & Cohen, 1990). Whilst childhood overweight and obesity have been directly linked to middle-age mortality and a range of chronic diseases in adult life, children can also face immediate health consequences of obesity including high blood pressure, asthma and Type 2 diabetes (Ho, Garnett, & Baur, 2014; Rimmer, Rowland, & Yamaki, 2007). Given that eating behaviours and obesity track across childhood and into adulthood (Lipsky et al., 2015), it is imperative that we understand the predictors of child dietary-related health before children reach school age.

Most research on early child eating behavior has focused on parental reports of children's eating and the impact that different parental feeding practices can have on child food consumption. This research suggests that overly controlling feeding practices tend to be counterproductive. For example, pressuring children to eat has been associated with more unhealthy eating behaviours in longitudinal research (Ellis, Galloway, Webb, Martz, & Farrow, 2016), whilst using one food as a reward to eat another food has been shown to lower children's liking of food that they are bribed to eat (see Holley, Farrow & Haycraft, 2017 for a review). Moreover, using food as a reward can predict emotional eating behavior longitudinally across childhood (Farrow, Haycraft & Blissett, 2015), and overtly restricting foods can lead to increased preference for those foods (Birch et al., 1980). Other practices such as encouragement to eat, teaching about nutrition, and modelling are thought to have positive effects on child food intake (Hendy & Raudenbush, 2000). Parents have a fundamental impact of the food choices and feeding practices used with preschool children, but at the same time increasing numbers of preschool children are also fed outside of the home, away from their primary caregivers. Changes in government legislation have supported the return of parents to the workplace, and 96% of eligible children in England now use preschool childcare, where they spend on average 21 hours per week (George & Hanson, 2007; Office for National Statistics, 2016). A child in full-time preschool care is likely to consume 20-25 meals or snacks there each week (Children's Food Trust, 2015).

Preschool staff are ideally placed to foster healthier eating behaviours with children yet surprisingly little is known about whether or how eating and feeding differs for children in nursery compared to when they are at home. The research that has been conducted suggests that nursery workers report using more positive feeding practices compared to parents such as encouragement to try new foods and modelling of

healthy foods (Elford & Brown, 2014; Johnson, Ramsay, Shultz, Branen, & Fletcher, 2013; Ventura & Birch, 2008) but this research does not account for differences between children, and there has been no research to date looking at whether nursery staff and parents differ in their use of feeding practices for the same children (i.e. paired reports). Using a cross-sectional paired participant design, this study aims to explore whether there are differences between parents and nursery keyworkers (the person responsible for the child's individual needs and for liaising between nursery and the child's parents) descriptions of feeding practices and eating behaviours for the same children in nursery compared to at home.

Methods

This was a cross-sectional quantitative survey using two structured questionnaires. Ethical approval was obtained from the School of Life and Health Sciences Ethics Committee at Aston University.

Participants

Parents of children over the age of 1 year were invited to participate in the study via letters which were sent home by interested nurseries or preschools in the Birmingham area, UK. Where caregivers agreed to take part, the child's keyworker was also invited to take part. In total 43 parent-keyworkers pairs participated. Mean parental age = 37 (SD =5.37); mean keyworker age = 31 (SD=7.56). There were 9 males and 34 female parents and 2 male and 40 female keyworkers. 67% of parents and 63% of keyworkers described their ethnicity as White. The average child's age was 36.5 months (SD=13.13) with 21 male and 22 female children (6 unknown). More meals were eaten at home (mean = 13 SD=4.01) than at nursery (mean = 7 SD = 3.56). However, all food eaten at nursery was provided by the nursery.

Measures

Parents and keyworkers completed the *Child Eating Behaviour Questionnaire* (CEBQ: Wardle, Guthrie, Sanderson, & Rapoport, 2001): a 35-item parent-rated questionnaire designed to measure eight dimensions of a child's eating behaviour. These 8 dimensions can be combined into two subscales "food approach" (which includes enjoyment of food, food responsiveness, desire to drink, and emotional overeating), and "food avoidance" (including satiety responsiveness, food fussiness, slowness in eating, and emotional undereating). They also completed the *Comprehensive Feeding Practices Questionnaire* (CFPQ; Musher-Eizenman and Holub, 2007): a measure of a range of different feeding practices used by caregivers, including pressure to eat, using food as a reward, restriction of food and modelling eating behaviour. The CFPQ for the keyworkers was adapted slightly, in that references to "my child" were changed to "the child," and "home" was changed to "nursery". Cronbach's alphas were run on the adapted scales (see Table 1) and only variables with alpha above .6 for both parents and keyworkers were included in the analyses because values below this are considered to indicate poor internal consistency (Bland & Altman, 1997; Glen, 2014; Peterson, 1994). The scales used were therefore involvement, using food as a reward, monitoring eating behavior, restriction of food for weight control reasons and modelling eating behavior.

Results

The mean scores reported in this study (Table 2) were in line with those reported in similar studies (Musher-Eizenman & Holub, 2007; Powell, Farrow, & Meyer, 2011). The majority of data was non-normally distributed, therefore Wilcoxon signed rank tests were used to explore differences in eating behavior and feeding practices between

Table 1
Cronbach's alpha values for sub-scales of the Child Eating Behaviour Questionnaire and Child Feeding Practices Questionnaire

	Cronbach's alpha	
	Parents	Key workers
Child Eating Behaviour Questionnaire		
Food Approach		
Food responsiveness	.73	.64
Emotional over-eating	.70	.70
Enjoyment of food	.88	.74
Desire to drink	.88	.77
Food Avoidance		
Satiety responsiveness	.70	.70
Slowness in eating	.62	.74
Emotional under-eating	.76	.63
Food fussiness	.93	.82
Child Feeding Practices Questionnaire		
Child control	.69	.32
Emotion regulation	.73	.53
Encourage balance and variety	.66	.50
Environment	.71	.38
Food as a reward	.79	.71
Involvement	.65	.73
Modelling	.77	.75
Monitoring	.91	.94
Pressure to eat	.60	.50
Restriction for health	.50	.68
Restriction for weight	.76	.66
Teaching about nutrition	.52	.73

parents and keyworkers.

As seen in Table 2, differences were found in perceptions of child eating behaviour with parents reporting significantly higher levels of both child food approach and child food avoidance behavior at home compared to the behaviours reported by keyworkers in nursery settings. Differences were also found in the feeding practices used by parents and keyworkers, with parents reporting significantly more use of food as a reward, involvement, modelling, monitoring, and restriction for weight control than keyworkers. Keyworkers reported using more modelling healthy eating behavior compared to parents.

Discussion

The results indicate that parents describe their children as displaying significantly higher levels of food avoidance and food approach behaviours at home compared to the reports from keyworkers for children's eating behaviours in nursery. Parents also describe using significantly higher levels of overly controlling feeding practices compared to nursery keyworkers, specifically using food as a reward for good behavior and restriction of food for weight control. In contrast nursery keyworkers reported less involvement in meal planning and less monitoring of food choices which is perhaps unsurprising given their role in meal preparation; however, they also reported more modelling of healthy eating in nursery. These findings corroborate other research by Johnson et al., (2013) and Elford & Brown (2014) who found that nursery staff used modelling, encouragement to eat and monitoring behavior, but they are the first to take into account individual differences between children and to demonstrate these differences when using reports for the same children.

Further research is required to explore further whether the differences reported in feeding and eating between parents and keyworkers are perceived differences or whether they reflect real differences in children's experiences with food in these two respective settings. It may be that the experience of caring for many children at one time, and the absence of the parenting attachment, lowers the perception of fussiness for keyworkers. In comparison, parents often respond to feeding difficulties with anxiety, which may in turn increase the perception of concern (e.g. Coulthard & Harris, 2003). Or it may be that children are

Table 2
Wilcoxon Signed-rank test of the differences between parents and keyworkers on perceived child eating behaviors and feeding practices used at home compared to in nursery

	Parents	Keyworkers	Wilcoxon value
	Median(range)	Median(range)	
Food Approach	2.69(2.38)	2.63(1.93)	138.00*
Food Avoidance	2.81(2.70)	2.56(2.30)	202.50*
Food as a reward	3.00(4.00)	1.00(2.00)	18.50***
Involvement	3.67(4.00)	3.00(4.00)	170.50*
Modelling	4.25(2.50)	4.75(2.00)	494.50*
Monitoring	4.38(3.00)	4.25(4.00)	148.00*
Restriction for weight control	2.13(3.00)	1.43(1.75)	70.50***

* p < .05 ** p < .01 *** p< .001

genuinely less fussy in nursery settings where they are exposed to modelling from other children (which can influence food preferences, e.g. Hendy & Raudenbush, 2000), and have less opportunity to refuse food or demand alternatives. Further observational research is needed to shed light on these questions.

Although this is a small cross-sectional study with a relatively homogenous group, we hope that the findings will add to our understanding of how and why children may differ in their feeding experiences and eating behaviours across these two settings. Further observational research is needed to explore in more detail how children experience the feeding dynamic differently in nursery compared to at home, and which factors in these two settings impact upon their experiences with food and eating. Importantly, feeding practices appear to be less bound in reward and restriction in the nursery setting compared to at home, which may in turn explain why food approach and avoidant behaviours are also less evident. Greater nursery-home communication around food and feeding may help to support parents who are concerned about child eating behaviour or weight.

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original article

Spotlight on MSc Research

"They called me instant king." A narrative analysis of the experiences of first year university international students' fruit and vegetable consumption.

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Introduction

Fruit and vegetable (F&V) consumption is on the decline among United Kingdom (UK) university students despite national campaigns to encourage consumption of the recommended daily intake(Robinson, Blissett, & Higgs, 2011). The World Health Organization (WHO) proposes an intake of 400 grams of F&V per day as a valuable part of a healthy diet(World Health Organisation, 2003). This forms the basis of the UK 5-a-day programme (five 80 gram portions or two fruits and three vegetables) (Department of Health, 2003; Henderson, Gregory, & Swan, 2002). This study focused on a small yet significant sector of the population – international students in UK universities. This category has been under studied because of the need for vast cross-cultural awareness and little guidance on how to design and conduct studies with this increasingly diverse (cultures, beliefs, backgrounds) population (Hughes, 2004; Nelson, Story, Larson, Neumark-Sztainer, & Lytle, 2008). We know that changing the eating behaviour of ethnically diverse university students is challenging and often unsuccessful (Rodgers et al., 2016).

As students transition to university, they experience a number of changes and differences to their eating patterns, which can create barriers to healthy eating. Typically, a university lifestyle is characterised by risky behaviour (binge-drinking, smoking), irregular eating and sleep patterns, poor diet, and work pressures; it is no surprise that students' F&V consumption is affected (Dodd, Al-Nakeeb, Nevill, & Forshaw, 2010; Papadaki & Scott, 2002). The shift from home to university or native country to the UK may have an impact.

Methods

We used a qualitative design where we asked for students' stories of their experiences and beliefs about F&V consumption. First-year undergraduate international students who were on-campus residents were recruited. Data are reported from eight participants (Table 1). The diverse sample is characteristic of the UK international student population(UKCISA., 2012).

We conducted semi-structured interviews using an interview guide (Table 2) with students completing their first year and could recount their experiences since moving to the UK. The interviews were transcribed verbatim and the stories were analysed for style and content using narrative analysis. This enabled in-depth exploration of students' experiences and their experience of acculturation in relation to F&V consumption (Berry & Sam, 2007; Murray, 2008).

Table 1
Participant pen portraits

Pseudonym	Biographical information
Benny	21-year-old Rwandese studying Multimedia computing and has lived most of his childhood with his parents in Belgium. Believes having grown up in Europe, he is already used to the lifestyle in UK and the fast-food culture. Acknowledges that majority of university students eat less F&V and there is room for improvement. He speaks of how the media advertises fast food and not F&V and believes it is likely to get worse for future generations. His turning point was coming to university and getting a lot of independence and freedom.
Matthew	22-year-old Korean studying Engineering. The first difference he recognises is the cooking style in UK. For his first term, he bought a lot of instant food (noodles), and then he went on to eat from the cafeteria and finally bought a rice cooker in his second term. Strongly misses home food and tries to look out for or cook some. His turning point was his friends calling him "instant king" and buying a rice-cooker. He acknowledges that other students eat more F&V than him and plans to change in second year; move into accommodation with other Korean students.
Mark	20-year-old Estonian studying Pharmacy. He has two jobs, at a hospital and as a waiter. His experience was quite easy as he had a friend in England prior to his arrival that helped him but confesses becoming home-sick. He was running out of money and to save some he spent one pound a day on food and cut out all F&V and certain meals. He was cautioned by his flatmate concerning his eating behaviours who advised him that, "money is not the most important, it's health." His turning point was getting a job, started to buy more F&V however, he got busier and started having fast-food but he feels he is eating more F&V than recommended.
Daniel	21-year-old Chinese studying Logistics management. He found significant differences in time and eating patterns. Has no interest in cooking like his girlfriend so finds it convenient to eat out. He prefers home food and walks to Chinatown to eat and shop.

(continued)

	Initially he never thought about what he ate and was more concerned of the taste and killing the hunger. Justifies his previous behaviour in general terms by frequently using "we Chinese students." His turning point was when he discovered he has a liver problem and now controls his eating and tries to have a healthy lifestyle.
Laura	20-year-old Hungarian living in Austria studying International relations and French. Brought up under strict family environment where you ate all that was on your plate. She had health problems in childhood, was forced to eat F&V, and later began to like them. Experienced a massive change in diet and shocked by prices of food on coming to UK. Partied a lot and ended up eating less healthily but hopes to get a job, spend more on F&V, and work towards healthy lifestyle with her friend. Now eating lots of F&V and healthily to lose weight and shape up for the summer.
Mary	22 year old Lithuanian studying combined honours - Biology and psychology. It is her first time away from home, living by herself, so she found it all new and challenging for her. She is very selective in her eating, likes F&V and eats healthily. She always ensures she eats right and is against unhealthy eating. Grew up at a farmhouse from childhood so was surrounded by F&V and nature and always ate produce from the garden. She worked on a farm and has the perception that most market foods have pesticides and chemicals. Her turning point was finding a new lifestyle from a friend linked to Vedas and has changed what she eats, time and amount she eats and eats more F&V and avoids meat as a result.
Elizabeth	19-year-old Romanian studying Business and Psychology. She loves travelling however found it a big shock and overwhelming but later became used to life in the UK and it got better. Does not think her diet changed and her biggest challenge was cooking for herself. Initially ate a lot in pubs, tried all sorts of British meals, did not have a proper eating pattern, missed meals and ate whatever she felt. Eventually learnt how to cook from her mother. She believes she is now eating healthily and living with her parents for 18 years has had a big influence. Strongly believes eating F&V is down to personal choice, holding onto past behaviours and not where you are.

(continued)

Esther	20-year-old Mongolian studying Economics and Management. It is her first time living independently for more than a month. Her biggest differences were the cooking style and presence of fast-food chains that they do not have in Mongolia. It was a completely new world. For the first six months, she ate fast-foods and no F&V, started drinking alcohol and partying a lot. She could not cook and always ate from KFC and McDonalds, gained lots of weight and thought she needed to change. Her turning point was when her mother told her she looked chubbier and this put her off, thinking that she needed to get back to her old self. She resorted to eating more healthily and plans to do better in second year with a friend

Table 2

Interview Schedule

1 Please share with me your background and lifestyle, the kind of food you eat back home.
2 Do you feel there is a big shift in all this, on coming to England?
3 Do you have an idea of the recommended daily intake of fruit and vegetables?
Probe: How do you know this information?
4 Do you have any programmes or policies in your home country concerning fruit and vegetable consumption?
5 What sort of foods do you consider as fruit and vegetables (in your country or here in the UK)
Probes: a.) What sort of fruit and vegetables do you like to eat?
b.) How often do you eat such/fresh fruit and vegetables in a week?
6 Please tell me about the fruits that you hadn't tried before coming to England or that are not common in your country?
Probes: a) Did you like the fruits? b) Any comparison to those you eat back home?
7 Why do you think it is important to eat fruit and vegetables? What is the value of eating F&V?
8 Do you often prepare your meals or do you prefer to eat at places such as fast-food restaurants?
9 Do you usually do activities like going out shopping, preparing and cooking meals with your flatmates?
Probe: Where do you shop? What are the frequent things on your shopping lists?
10 Why do you think many young people prefer buying fast food or prepared meals and not fruit and vegetable?
11 What do you find challenging concerning fruit and vegetable consumption or what is it about fruit and vegetable that you dislike?
Probe: Is it the shopping, preparation, cooking, variety?
What do you think takes more time: premade food or fast foods or fruits and vegetables?
12 How has being away from home affected/ influenced your eating patterns, food preferences and meals especially fruit and vegetable consumption?
13 How do you rate availability and accessibility of fruit and vegetable here as compared to your home country?
How do you feel about eating fruit and vegetables while here? (Relating to quantity and quality).
Probe: Do you have any plans or strategies you have laid out to increase your consumption?
14 Other than eating fruit and vegetables on their own, are there other ways you eat them both here and back in your home country?
Prompt: for example, mixed with other food as part of meals, making fruit juices.

Results

The tone of participants' accounts was largely of surprise at the difference between their native countries and UK. There was also evidence of anxiety in participants' accounts in relation to establishing friendships, managing academic work and financial constraints.

Fast-food culture versus home comforts

Coming to the UK meant that the students were away from their familiar socio-cultural environment and had to learn how to behave within a different setting. The students mentioned that life in the UK had a strong attachment to fast-food compared to their home countries affecting their F&V consumption.

Benny: *Fruit and vegetables is not a big thing for uni students even those who are born here. If fast-food was not popular then we would not have many restaurants and shops selling it everywhere, it is outrageous, it's like people are addicted to it.*

A key concern was the significant availability and accessibility of fast-food compared to F&V, which for them led to reduction in F&V consumption.

Elizabeth: *In Romania, you have people selling fruits and vegetables on the streets and you could just get it from anywhere and it's really good. Here, you have to go to a proper market or go to Tesco, Sainsbury's whatever, it's not as juicy and tasty anyway or sometimes you don't find what you are looking for which has affected my eating fruits and vegetables.*

Fending for oneself

On moving to university, students expressed satisfaction in relation to their independence and freedom from parental influence.

Matthew: *moving away from home means that I eat from where my parents do not see, away from all their comments so I become more free and feel free to choose what I want to eat and I feel am in control over myself and my choices.*

Peer influence became important in relation to food choices, which affected students F&V consumption.

Esther: *When I came here I straight away started eating KFC and McDonalds, you know. I started hanging out with home students in everything you know they party hard, drink a lot but rarely eat vegetables or fruits (laughs)*

Fending for oneself also meant learning how to shop for groceries in a new country. Some participants were either reluctant or could not cook and found it difficult to prepare healthy meals from scratch opting for ready meals or fast-food.

Matthew: *Cooking made me think about what I eat and affected my daily routine so with the rice cooker, I could avoid instant food and going to the university café. With the rice cooker, I started looking for recipes of how to cook more healthy meals.*

Matthew had been nicknamed "Instant King" because he ate instant noodles for the entirety of his first term at university before he bought a rice cooker.

Health is not a priority

Although the students were aware of recommended amounts of F&V in the UK and their own countries, they did not prioritise their health and this did not always influence their food choices.

Esther: *I don't think I have it at the back of my mind that I need to eat this much fruits and vegetables and no one really talks about 5-a-day, I just read it on juice boxes.*

Others pointed to the fact that they were still young, which meant that health was not prioritised and eating related conditions were considered irrelevant.

Daniel: *Actually we don't always think about how much we are consuming even for fruits and vegetables. I eat so I don't feel hungry because I think am still really young, I don't think about the health concerns so I eat to fill myself up. What I eat, I don't care but the taste; I care*

(laughs).

Discussion

The differences to their native countries in relation to meal times, food availability, and fast-food culture expressed international students' experiences of living in the UK. Relocation into a new culture at a time of transition into adulthood meant that students had to acclimatise to a new way of living in an unfamiliar environment. The change of environment creates fundamental changes to students' subjective norms and perceived behavioural control in relation to F&V consumption. Moving into another culture, and living away from home had a significant impact on food choices and eating habits (Papadaki & Scott, 2002).

Understanding the effect of cultural diversity on F&V consumption is crucial, as international students require support to adjust to a new culture, lifestyle and diet. This could boost control beliefs in relation to their ability to consume F&V despite the environmental changes. Furthermore, the availability of fast-food restaurants close to university, which become meeting venues among friends may foster fast-food vs. F&V consumption (French, Story, Neumark-Sztainer, Fulkerson, & Hannan, 2001).

With university life structured around independent living, the newfound autonomy to shop, cook and prepare a meal from scratch was challenging, thereby affecting their perceived behavioural control to consume F&V. With increased autonomy and limited parental supervision, their subjective norms were affected as many students adopted lifestyles acceptable by peers making them susceptible to reduced F&V consumption, unhealthy eating, alcohol and smoking(Pearson, Ball, & Crawford, 2012). In circumstances where social pressure influences students' diet and eating habits, improving self-efficacy to resist peer pressure may be effective (Bruening, Kubik, Kenyon, Davey, & Story, 2010).

Eating F&V became an exception rather than the norm influenced by the easy accessibility of fast-food or ready meals perceived as tastier, cheaper, convenient and quicker (Edwards & Meiselman, 2003) reflecting the negative impact of the 'McDonaldization' of university life(Ritzer, 2008). Health was not always a motivator for students' food choices as their behavioural beliefs that health was not a priority influenced their attitudes and intentions towards F&V consumption.

Recommendations

In order to change international students' eating behaviours and food choices in a way that will increase their F&V consumption, campaigns should include composite initiatives tailored towards addressing the need for F&V consumption beyond providing information. They need to tackle the context in which students are living, their motivations and intentions for choosing F&V, and their skills in relation to grocery shopping on a budget and cooking meals from scratch.

International students need a bespoke approach, as the context in which they are situated is foreign compared to home students. They are prone to acculturative stress due to cultural transitions from marked differences between their native countries compared to the UK. Additionally, the diversities of the international students' backgrounds creates a multi-faceted population with a lack of homogeneity in various spheres – culture, eating behaviours and lifestyle. Therefore, little generalisation of interventions is feasible.

Conclusion

The students experienced significant changes in their eating habits and lifestyle patterns since going to university overseas. Many students were able to recognise and confirm their current decline in F&V and increase in fast-food consumption.

Tackling F&V consumption among this group is complex and requires addressing their attitudes towards F&V, rewarding health subjective norms, encouraging positive perceived behavioural control and fostering their intentions to consume F&V. International students may have intentions and strive to consume the recommended F&V intake; however, these intentions are rarely transformed into behaviour due to lack of implementation-intentions like planning the meals, shopping, preparing and cooking the F&V and lack of knowledge of the recommendations.

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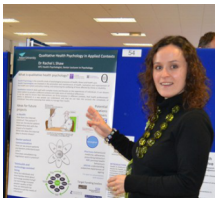

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editorial

A brief introduction from Val Morrison, Grants Officer of EHPS EC

Val Morrison
Grants Officer of EHPS EC

The reports below demonstrate how relatively small amounts of funding from the EHPS EC Grants Committee can provide early career researchers – talented PhD students and postdoctoral students —with a great opportunity to learn new material, communicate their own science, and make new contacts .... whilst also having fun! THE EHPS Grant scheme runs annually for EHPS members, with competitively funded awards for Conference grants (subject also to an accepted presentation); and CREATE and SYNERGY workshop grants (also subject to acceptance on the workshop). All submissions are subject to dual review and are awarded based on a personal statement demonstrating research relevance, and the need for, and potential added value of, EHPS funding support to their research career. It is our hope that awardees will present a brief report of their attendance for publication in this Newsletter. Below are the reports from several of last year's successful grant awardees which I hope you find interesting, and possibly inspiring!If you are thinking of applying keep an eye on our website for this year's call.

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grant report

Reflections on 31st Conference of the EHPS: Innovative Ideas in Health Psychology.

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The PhD research I am conducting explores the psycho-social experience of lesbian, gay, bisexual, and trans* (LGBT) individuals living with the chronic condition of multiple sclerosis (MS). I am employing an innovative multi-method qualitative approach which incorporates verbal and visual data, in the form of interviews and participant-authored photographs. The study is posited within a critical health psychology epistemological paradigm and it is theoretically infused by notions from phenomenological psychology and visual ethnography creating an integrative methodological framework (see Papaloukas, Quincey & Williamson, 2017). Thus, I find that the conference's main focus on innovative ideas in Health Psychology was appropriate and extremely constructive in regards to my own research.

More specifically, my attendance at the conference provided me with invaluable benefits covering a number of domains. I will mainly focus on three of those, which I consider most important. 1) It allowed for dissemination of aspects of my research, which is a concept linked to the core of my theoretical framework. 2) It gave me the opportunity to receive constructive criticism and feedback, and to learn about innovative forms of conducting research in health psychology. Finally, 3) it provided me with the opportunity to create new research connections, and nurture already established ones in a pan-European level. In detail:

1) I was able to showcase aspects of my research to a diverse audience via my oral presentation "Living with MS: Visual and verbal accounts of adjusting to disability and ableism in the LGBT community" (Papaloukas, Williamson & Fish, 2017). The presentation focused on both methodological and analysis-related outcomes. Specifically, the incorporation of visual (participant-authored photographs) in qualitative health research. Further, I discussed the Public Engagement event which I organized earlier in 2017 (see www.lgbt-multiple-sclerosis.com). I argued for dissemination in collaboration with participants beyond academia, but also (and most importantly) I posited health psychology research with vulnerable participants/patients within a collaborative, participatory paradigm. Simultaneously, I provided some examples with regard to the analytical incorporation of the visual into a complete analysis pertinent to post-diagnosis adjustments of LGBT persons living with MS. I received positive feedback from members of the audience, and also comments which were constructive and allowed me to enhance the quality of my work as I refine it, in these final stages of my PhD study. For example, members of the audience highlighted the importance of ethical considerations, especially in regards to incorporating the visual in health psychology research. Also, discussion ensued, and concerns and suggestions were provided concerning the inclusion of healthcare providers (e.g. neurologists) in Public Engagement events.

2) I had the opportunity to attend presentations from experienced and novice researchers alike. That has stimulated plans for developing or refining my current work and has also provided ideas for my

post-doc research plans. More specifically, I found extremely interesting the presentation from Clare Uytman in regards to the phenomenological exploration of prosthetic-patient communication (Uytman, 2017). Also, relevant to my current and future research plans, was the fascinating symposium chaired by Maria del Rio Carral concerning the qualitative – quantitative divide (del Rio Carral, 2017). Some important notions were proposed by the presenters which helped me to better comprehend the importance of good qualitative research and generated ideas as to how to enhance my own qualitative health psychology research. For example, the conclusion that good qualitative work should be a slow procedure with solid theoretical foundations resonated with my own understandings of a labored qualitative project. Also, the realization that themes do not just emerge independently from data but they are the outcomes of an active analysis procedure assisted by the combination of the researcher's expertise and the participants' narratives was of equal importance (Chamberlain, 2017). In addition, the incorporation of the socio-structural and political components of the health and illness experience by Roberto De Vogli highlighted the current socio-political situation of austerity in European societies and its severe effects on marginalized social groups, especially in a health context (De Vogli, 2017). This component is extremely appropriate for my own research, as the current political situation in the UK, with years of ideologically related induced austerity (e.g. severe benefit cuts), has profoundly impacted the well-being of individuals living with chronic conditions, MS specifically, and has further created inequalities for disabled individuals. Finally, the poster sessions provided me with the opportunity to 'explore', in detail, research conducted at a European level, equipping me with knowledge about the current health and illness situation in Europe and the world (e.g. erectile dysfunction in Slovakia, (Masaryk, 2017), cancer screening in Turkey (Naivar Sen, 2017), Lupus experience in a pan-European context (Mazzoni, 2017) etc.).

3) Lastly, the aspect of networking and conversing with researchers from all around Europe (either with similar or different research interests) has spurred initial discussions and debates for potential collaborations. This brainstorming of ideas within such a mentally stimulating environment has produced specific suggestions for future research partnerships, which include research grants bids in the field of chronic illness, and sexual health (e.g. MS related bids; HIV intervention bids in a number of different countries), academic collaborative endeavours(e.g. systematic review on sexual health), and suggestions for potential post-doctorate roles. These components of active participation to the conference has enhanced my personal, and professional background as a PhD researcher, and a scholar-activist with research contacts in a number of different European countries (Cyprus, Greece, UK).

Conclusion

In conclusion, this grant and the funding of my attendance to the conference has allowed me to present my work to an expert audience, receiving constructive feedback. It has provided me with an increased intellectual stimulation which subsequently aides towards the refinement of my work, and has also spurred discussions and generated research networks for further work in health-related research in a European context.

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special issue

Networking and more. Reflections on the 31st EHPS Conference

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When I, a final year PhD student at the Department of Psychology, University of Konstanz, boarded the train to attend the 31st EHPS Conference in Padua, Italy, I had just begun to transition from being a PhD student to becoming a postdoctoral researcher. The submission deadline was set for the end of the year, a very first draft of most chapters just written, potential postdoctoral research projects proposed, and the stress-level slowly but surely rising. Some might think that attending a conference at this stage contributes to the stress and takes up valuable time that could better be spent writing, however, I would argue that attending a conference in the final year of the PhD is beneficial: not only is it vital for an academic career, but it can also be a great motivational boost for continuing to do research.

Two important career benefits of attending conferences that are often highlighted are the opportunities for presenting and discussing one's work as well as networking with researchers working on similar topics. Both can be achieved by organising a symposium, so I submitted a symposium on the uptake, acceptability and use of digital behaviour change interventions (DBCIs) to the 2017 EHPS conference. Four early career researchers, all whom I had met at previous EHPS conferences and CREATE workshops and who share my interest in digital health, followed my invitation to present their work. To provide the viewpoint of a senior researcher, Dr. Felix Naughton (University of East Anglia, United Kingdom) was invited as a discussant. The overarching goal of our symposium was to connect researchers to jointly advance the development of DBCIs by acknowledging and better understanding individual differences in using DBCIs. Therefore, presentations covered a great variety of health behaviours and chronic conditions as well as a range of methodological approaches.

Jan Keller (FreieUniversität Berlin, Germany) opened the symposium by discussing psychological mechanisms of an online intervention targeting eating behaviour. The presented results highlighted that including evidence-based behaviour change techniques such as planning and self-efficacy in DBCIs may enhance their efficacy. Next, I presented a stage model approach for assessing the motivation to adopt mHealth apps targeting eating behaviour and physical activity. Results showed substantial sociodemographic and motivational differences between mHealth app users and non-users as well as between subgroups of non-users. This underlined the importance of taking differences between mHealth app non-users into account when designing and promoting DBCIs for new target groups. In the two following presentations, qualitative findings from focus groups and interviews were discussed with different foci. Emma Carr (NUI Galway, Ireland) presented the perspective of potential users of a planned breast cancer awareness intervention where her results highlighted the importance of aesthetics, ease of use and credibility of DBCIs for a successful uptake. Next , Eimear Morrissey (NUI Galway, Ireland) discussed general practitioners' (GPs)views on DBCIs, as they are important stakeholders for their distribution. While GPs appreciated the

empowerment of the patient using DBCIs, they expressed concerns about responsibility and limited outreach of the interventions, thinking that they might be most appealing to the worried well. Lastly, Olga Perski (UCL, United Kingdom) presented the development of a self-report measure of engagement with DBCIs. By integrating findings from a systematic review and qualitative interviews, an operational definition of engagement was developed that highlighted that engagement might be a state-like construct that is both behavioural and experiential.

As discussant Felix Naughton concluded, despite their differences in target behaviours, methodological approaches and research questions, the presented studies identified engagement with DBCIs as a major challenge in the design and application of DBCIs. Our symposium showed that it is not only important to evaluate the effect of a DBCI on behavioural outcomes, but also to understand why and how people are using them. Furthermore, the symposium highlighted that DBCIs cannot be seen as a 'one size fits all' approach. Instead, differences between potential users and stakeholders need to be taken into account when developing DBCIs, because different target groups might have different needs and preferences. The symposium provided starting points for future research on DBCIs, such as studying motivations for DBCI use and engagement with DBCIs in a systematic way and involving potential users and stakeholders in the design process.

Taking part in this symposium has provided me with the opportunity to present my work to an interested audience and to network with other researchers interested in similar topics. In addition, it made me once again realise that being a health psychology researcher is a highly fulfilling and exciting profession, and that continuing to work in academia was the right choice for me. The symposium highlighted avenues for future research, and I left the lecture hall inspired, with many ideas for future research studies. It also was a pleasure to exchange ideas with other aspiring young researchers in the field: having identified numerous commonalities in our work, I hope that we will be able to collaborate in the future and organise many more thought-provoking symposia.

I would like to thank the EHPS EC Grants Committee for providing me with the great opportunity to attend this conference, present my work and exchange ideas with other researchers interested in digital technologies in health care. While now preparing my thesis for submission, I feed on my boosted enthusiasm for DBCIs (and the sunshine!) that I took home with me from Padua, and I am very much looking forward to join the conference again in 2018 in Galway.

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grant report

Highlights and reflections from the CREATE Workshop 2017: Planning Health Promotion Programs

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Sincere thanks to the European Health Psychology Society for awarding me a CREATE grant to attend the 19th CREATE workshop "Planning Health Promotion Programmes: an Intervention Mapping (IM) Approach" facilitated by Prof Gerjo Kok, Prof Rob Ruiter and Dr Rik Crutzen (Meade, Gatting, & van Beurden, 2017).

I was excited when I learned that IM was the focus of this year's CREATE workshop. I first learned about this approach (Bartholomew, Parcel, & Kok, 1998) almost ten years ago when I was studying for my Masters in Health Promotion. While I have not used IM fully in practice, I recognise its many strengths. For example, its step-wise approach to develop theory- and evidence-based interventions, and the consideration it gives to both individual and environmental factors that influence behaviour. Coming from a public health background, this is of prime importance to me; sometimes I feel that individual factors are over-emphasised in current debates and interventions. We should instead be focusing on the multiple levels of influence on behaviours, whilst including a focus on individual behaviours (Sniehotta et al., 2017). I also value the emphasis that IM places on involving different stakeholders and information sources.

I was unsure about applying for the CREATE grant as I thought it would be a long-shot. That said, my motto is 'apply for everything', so I did, and thankfully I was successful. Without the funding, I would not have been able to attend CREATE or EHPS2017. I felt that it was a critical year to attend. While I am currently pursuing my PhD in Psychology within the Health Behaviour Change Research Group at NUI Galway, my background is in nutrition and health promotion. I was entering the third year of my four-year PhD and was keen to develop my international networks in health psychology. Up to that point, I had been focusing on presenting at national and international conferences specific to my topic area. I have been familiarising myself with recent research developments and debates in health psychology (Quinton, 2017) since starting the PhD, while also refining my research proposal and starting my systematic review. It felt like the perfect time to engage with the EHPS community, and I felt ready to do so. And it didn't disappoint.

Participating in the CREATE workshop was a wonderful opportunity to learn more about the theoretical and practical application of the IM approach, from the leaders in this area. The facilitators provided a brilliant overview of the principles and processes of IM. For me, however, the highlight was the practical examples that illustrated how they have applied the approach, what challenges they faced, and how they overcame them. I found this particularly reassuring. IM is a very detailed approach and I can see how it may be challenging to implement due to resource constraints and competing priorities. It was also useful to apply the process in our smaller groups to selected topics. It gave us an opportunity to discuss the six steps to enhance our understanding and draw on the insights and experiences of other groups members, in relation to

IM itself or the health-related topic being addressed. This was incredibly useful as I had the opportunity to think about how I could apply it to my own research, even aspects of the approach, e.g. selecting a behaviour to focus on, theory, or behaviour change methods (Kok et al., 2016). I also felt a real sense of achievement over the two days as I was able to draw on what I have learned over the past two years of my PhD regarding theories and principles of behavioural science, and my practical experience prior to this. I met lots of wonderful people, and potential future collaborators during the workshop, and benefitted enormously from the sharing of ideas and experiences. It was great to have a forum to do this in; it solidified the learning for me. I am excited about drawing on this learning to further inform my PhD work in the area of early life behavioural interventions delivered by health professionals to prevent childhood obesity.

The CREATE EC did a fantastic job in organising the workshop. It was great to have the opportunity to meet with other workshop participants during the pre-workshop networking event on the Sunday afternoon. The activities were well-structured so I had the opportunity to meet other attendees and hear more about them and their work. This made it much easier to engage in discussions during the workshop. I found that I had lots in common with others, be it in relation to my research topic or methodological interests, or my PhD experiences. It was beneficial to have the opportunity to share these with others and discuss strategies. This continued over the two days of the workshop and the conference itself.

The conference was fantastic also. Again, I met lots of wonderful people and really benefitted from the thought-provoking presentations and discussions over the four days. I came away with lots of ideas for the systematic review that I am currently completing, in terms of my methodology, such as issues surrounding the coding of behaviour change techniques in control groups (de Bruin et al., 2016), and how I will write up the review for publication. I found the discussion with people around my poster and PhD topic especially useful. During both the workshop and conference, I had time to reflect on my PhD projects and think about how I might conduct them differently, or indeed, report them more systematically and discuss the results of them in a more critical light.

Many thanks to the workshop facilitators and the CREATE EC and to the EHPS EC and specifically the Grants Committee for funding support to participate in the workshop. I would encourage other early career researchers to attend the CREATE workshop and EHPS conference, and to apply for the CREATE and EHPS grants to enable them to do so. I left Padua feeling more informed, inspired, re-invigorated and part of a community.

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grant report

Translating Health Psychology Research into Health Policy and Practice: Reflections from Intervention Mapping

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Despite mounting discourse on the need to better translate health psychology research into policy and practice, progress is needed. Researchers in health psychology have pushed and created frontiers in psychology and behavioral medicine in past decades, but translating our theoretical and empirical knowledge into policy interventions will further ensure that our fruits of labor achieve their maximum potential. As I situated this research-practice gap, two possible mechanisms became salient during my participation at the 2017 CREATE Workshop on Intervention Mapping (IM). First, the systematic processes of planning and implementing interventions create opportunities for researchers to leverage policy makers and practitioners' existing influence and expertise in the field, therefore advancing our work closer to the nexus between research and practice (Kok et al., 2016). Second, multi-level thinking underlies IM, allowing us to conceptualize how individual-level constructs transcend and manifest in groups, organizations, communities, and beyond(Morgeson & Hofmann, 1999). As a researcher in health policy and management with training in health psychology, understanding these two aspects of IM brought insight into how I can combine paradigms from both disciplines for research that will yield higher impact.

The core of IM includes a 6-step iterative approach in the development of health promotion interventions: 1) conducting needs assessment/ problem analysis, 2) specifying change objectives, 3) selecting theory-based intervention methods and practical applications, 4) integrating these practical applications into an organized program, 5) planning for adoption, implementation, and sustainability, and 6) creating an evaluation plan (Bartholomew Eldredge et al., 2016; Kok et al., 2016). Health psychology theory yields the highest impact during steps 2 and 3. But interventions do not exist in a vacuum, and further architecting a continuous interface between the intervention developers and users during steps 3, 4 and 5 is crucial to ensure its effectiveness. Kok et al. (2004) referred to this as the "linkage system." The explicit need to create this interface for interactions and information exchange paves the way for a stronger role for, or closer collaborations with, policy makers and practitioners. This is especially key for health issues and interventions at the policy level. Addressing these issues requires concerted efforts among various stakeholder groups, and IM generates a framed opportunity for theory users to precisely integrate practitioners' field expertise for enhanced feasibility, diffusion, and effectiveness (Kok et al., 2016).

As an example, unintentional injury is the fifth leading non-disease cause of death in the U.S., with 33,091 deaths due to opioid overdoses in 2015 (Centers for Disease Control and Prevention, 2016, 2017). At its core, the opioid epidemic has arisen from drug diversion and abuse at the individual level, but individual psychosocial interventions have not been effective in mitigating the problem (Amato, Minozzi, Davoli, & Vecchi, 2011). This necessitates policy solutions, such as prescription drug monitoring programs (PDMPs), which are opioid prescription information databases at the state-level for clinical, law enforcement, and public

health purposes that involve multiple stakeholder groups (Rutkow et al., 2017). PDMPs are by definition a policy solution, but it essentially is a form of behavioral change intervention that includes the conditions, actions, and actors in opioid users' social and physical environments in its design and implementation (see Commers, Gottlieb, & Kok, 2007). A case in point is the Institute for Behavioral Health at Brandeis University, which is one of the centers of excellence in the U.S. that conducts research and interventions to address the opioid epidemic. Their three-pronged approach to mitigate the increasing phenomena of deaths due to opioids overdosing is as follows; i) behavioral change for opioid prescribers, ii) PDMPs for surveillance, and iii)ensuring access to and high quality of addiction treatment (Pearlstein, 2017).

Second, implicit to IM and the translation of research to policy and practice is the importance of multi-level thinking. Kok et al. (2004) pointed to the need to organize methods and strategies at "each ecological level" when selecting the underlying theories for interventions. I expand on this view by drawing from scholarship in organizational behavior, as this discipline has been articulating issues related to multi-level theory and research development for decades (e.g., Klein & Kozlowski, 2000; Mowday & Sutton, 1993; Rousseau, 1985). Scholars in organizational behavior are driven to contemplate these issues, in part, by the need to delineate the influence of individuals yield on groups and organizations to better understand organizational phenomena (Mowday & Sutton, 1993). In the same vein, if health psychology researchers can apply such thinking, and extend individual-level constructs into higher levels, we might be able to create new paradigms to apply our knowledge in ways that policy makers and practitioners will view with immediate relevance.

For example, health psychology researchers are familiar with the construct and impact of self-efficacy on individual behaviors, but it also has profound implications in teams, within organizations, and for organizational development and change(Cummings & Worley, 2014; Gist, 1987). In implementation science, the organizational readiness for change concept builds directly on Albert Bandura's work. Weiner (2009) refers to this concept as "organizational members' change commitment and change efficacy to implement organizational change" (p. 2). This is not to suggest that conceptualizing multi-level research within health psychology is straightforward. Crucial thought must still be given to conceptualization and measurement issues to avoid anthropomorphizing higher level entities or institutions with individual-level constructs (Klein, Dansereau, & Hall, 1994), but there are certainly avenues to apply multi-level thinking in health psychology, and moreover in theoretically-driven ways (e.g., Morgeson & Hofmann, 1999).

Immersing myself with the IM method has provided two forms of insight to better translate health psychology research into policy and practice: structured opportunities to leverage policy makers and practitioners' familiarity and field expertise for interventions oriented at communities or populations, and the application of multi-level thinking. It is my hope that these brief propositions will spur thought on the ways we can conduct research in health psychology to generate higher impact on policy and practice.

Acknowledgements

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grant report

EHPS Conference Report

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I am very grateful to have been awarded the 2017 EHPS conference grant, which allowed me to participate in such a renowned, and interesting, international conference. The quality of all aspects of the conference including workshops, presentations, poster sessions and social events was extremely high. The week in Padua was enjoyable and inspiring and my participation will most definitely benefit my current and future work in health psychology.

For me, the conference began with the workshop on *Writing High Impact Scientific Papers and Getting Them Out for Review*, which was delivered by James Coyne. This was incredibly useful to a PhD student embarking on their publishing journey. The workshop provided some excellent advice and information about online tools and digital resources that are useful for keeping up to date with literature and finding appropriate journals for publication. This workshop also covered how to write a good title, abstract and cover letter that will stand out, get your paper out for review, and increase the ease of access to your paper through database searches once it is published. Journal impact factors and altmetrics were discussed, helping us to effectively distinguish between high quality and poorer journals. The workshop was informal and interactive, utilising research examples from the participants and this facilitated interesting discussion. James Coyne highlighted the importance of media presence both before and after publication and he gave the good advice that if you don't define yourself on social media, social media will define you!

One of the strengths of the EHPS conference is the variety of sessions on both specific research topics and broader areas that are applicable to researchers in multiple fields. I was impressed to see the array of presentations relevant to my specific research area, family and child eating behaviours. I found it particularly interesting to hear about the variety of methodologies researchers are using in eating behaviour research and the facilities and laboratories available in different universities such as the Experience Room in Wageningen University in the Netherlands (Spook, Wijk & de Vet, 2017). It was interesting to think about how the findings from lab based research compliments, and sometimes contradicts, the qualitative research I am working on as part of my PhD and what this might mean for future research.

Other, more general, conference tracks were also of interest and expanded my knowledge in areas such as intervention development and behaviour change. I am familiar with the behaviour change taxonomy (Abraham & Michie, 2008) and it was great to hear about the progress made in the development of a modes of delivery taxonomy (Carey, Jenkins, Williams, Evans, Horan, et al., 2017) and population and setting taxonomies (Marques, Carey, Williams, Jenkins, Finnerty, et al., 2017). Attending this conference certainly developed my knowledge in the area of behaviour change and intervention development which will be particularly useful to me in the future as I hope to be able to translate my PhD research findings into practice.

There was exciting energy and engagement throughout the conference. I found that the

interactive discussion, group work and idea generation activities during some of the symposia worked really well and it was good to see that some of the outputs of these discussions might contribute to developments beyond the conference. In addition, poster sessions were busy and provided a great opportunity to network and engage with other researchers. During symposia such as *Maximising value of qualitative methods in the development and evaluation of behaviour change interventions* and poster sessions, I had the opportunity to discuss one of my core research interests, qualitative research methods, with others researchers. In particular, I discovered some novel methods for carrying out qualitative interviews with children, which will definitely influence how I approach this type of work in the future.

The keynote speakers were excellent and again provided interesting information relevant to a broad audience. In particular, I felt that the keynote *Healthcare social media (#HCSM)*: A new approach to studying and promoting health behaviour (Pagoto, 2017) highlighted an important theme that ran throughout the conference - the importance of engaging with the rapidly evolving world of social media. This opened my eyes to numerous creative and innovative ways that we can use social media, not only for networking and promotion of our research, but also for the delivery of health interventions.

Overall, EHPS2017 was one of the most interesting, diverse, thought-provoking and enjoyable conferences I have attended. Again, I would like to thank all of the organising committee and wish to specifically acknowledge the grant scheme for enabling my participation.

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grant report

New frontiers in Health Psychology and Implementation Science

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The EHPS Synergy Expert meeting has now been championing collaboration and innovation in core fields of health psychology theory and research for 15 years. This year's meeting, which focussed on the synergy between health psychology and implementation science, was no exception. Over two days, Professor Molly Byrne (National University of Ireland (NUI) in Galway) and Dr Justin Presseau (University of Ottawa) brought together and led 22 psychologists working across and beyond Europe. Our mission was to take stock of the current linkages and status quo and generate solutions to key challenges, in the beautiful setting of Padova.

Implementation Science is the interdisciplinary scientific study of methods to promote the uptake of research evidence into practice, to improve health care quality and effectiveness (Eccles and Mittman, 2006). Despite billions spent on researching medical treatments, estimates suggest that a large proportion of the population may not receive recommended care: 30-40% for acute or chronic health conditions and 50% for preventive care in the USA (Schuster, McGlynn, & Brook, 1998). Medical advances have been termed 'all breakthrough, no follow through' (Woolf, 2006) and in Europe as well as the USA, far more is spent on discovering new treatments than researching how to deliver them 'promptly and properly' (Woolf, 2006).

Implementation Science is inextricably linked with behaviour change. Any improvement to routine health service delivery requires individuals working within the service to change one or more aspects of their practice, which can be measured, understood and intervened with by psychologists! Health psychologists have already contributed substantially to this young field, both through applying classical behavioural theory and methods and developing novel approaches (e.g. Godin, 2008, Francis, 2010, Michie et al. 2011). We may offer theory and methods to implementation science to understand behavioural determinants of practice change and to develop practice change interventions (Byrne-Davis et al. 2017, Colquhoun et al. 2017). However, there is also a huge research-practice gap in health psychology with huge numbers of seemingly effective health promotion, self-management and health professional interventions never finding their way into routine practice. Health psychology may therefore have much to learn from implementation science in how to scale up and implement effective health psychology-based interventions.

The Synergy meeting had three main aims: 1) to take stock of the current state of Implementation Science and what Health Psychology is currently contributing to the field of Implementation Science, 2) to use the experiences and expertise of participants to identify the unique challenges relevant to implementation of Health Psychology interventions, and 3) generate solutions to these challenges. Our planned output was one or more group-authored articles to submit for publication; key inputs to the meeting undeniably included copious cups of coffee and a variety of delicious mini pastries provided regularly to assist our thinking.

On day one, we introduced ourselves with brief

presentations on our experiences in health psychology and implementation science. These highlighted our diversity in working in projects in higher and lower income countries across the world, but also the similarities in challenges and opportunities encountered. Justin then provided an informative and engaging introduction to implementation science and his perspective on health psychology contributions so far, suggesting that further synergy will push both fields forward. This stimulated a lively discussion, deftly facilitated by Molly who helped us distil the aim, type, and audience for our target journal output, before we broke into groups to consider paper structure. Following this, we set off for the other essential parts of the Synergy meeting: a guided tour of beautiful Padova and a delicious dinner in a local restaurant.

Day two dawned brightly. Fuelled by more jet-black, 'stand your spoon up in it' coffee, we planned content and began to write in section sub-teams. Once reconvened we discussed ideas and any difficulties encountered, future plans for collaboration and networking, opportunities for international funding and, being health psychologists, action planned our way to an early paper submission (watch this space!)

For me the Synergy meeting offered invaluable experience, helping me develop both professionally and personally in a number of ways. Firstly, I was glad to discuss and reflect on some of my experiences at the 'coal face' of implementation science, having worked for the past seven years to influence practice from within the system as a practitioner health psychologist in multi-disciplinary teams. It was fantastic to compare experiences and challenges with others working in this way. I also came away with a deepened understanding of the implementation science field, including seminal papers and concepts. This has already influenced work projects, such as the Teams Together programme, where University of Manchester Health Psychologists Dr Lucie-Byrne Davis, Dr Jo Hart and I are working with four integrated care teams in the UK helping them adopt new ways of working using implementation science. Synergy helped me recognise that implementation is a crucial intervention in itself, and we now have a multi-facetted dissemination and implementation plan.

In terms of personal learning, beforehand I was fascinated to think about the meeting's process, or how the leaders would distil 22 participants' diverse views and experiences into a coherent, co-written paper. After all, psychologists are trained in critical thinking and are known for being a rather opinionated bunch! I was impressed by how expertly Molly and Justin managed to stimulate discussion and harness views whilst gently keeping us on task. Molly's facilitation style meant that whilst we were all aware when a spur of the moment left-field suggestion of ours did not meet the grade, we felt thoroughly appreciated for making it! Finally, the meeting allowed connections with other researchers and has sparked further development and joint work. For example I was delighted for the opportunity to visit NUI Galway in October for teaching and collaboration with Molly's health behaviour change research group (#loveirishresearch!) and Manchester Implementation Science Collaboration are enjoying planning work with Justin and colleagues in Ottawa to extend both groups' work on coding techniques in health professional training courses (Pearson et al. in submission).

Overall then, I was thrilled to be able to attend this excellent Synergy meeting, which very much met its aims. I would like to thank our meeting facilitators, the Synergy organising board in 2017 and the University of Padova for hosting the event, and especially the EHPS EC Grants Committee for supporting me with a Synergy grant to attend.

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