

1 **Are dietary interventions with a behaviour change theoretical framework effective in**  
2 **changing dietary patterns? A systematic review**

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## 15 **Abstract**

16 **Background:** The term ‘whole dietary pattern’ can be defined as the quantity, frequency,  
17 variety and combination of different foods and drinks typically consumed and a growing body  
18 of research supports the role of whole dietary patterns in influencing the risk of non-  
19 communicable diseases. For example, the ‘Mediterranean diet’, which compared to the typical  
20 Western diet is rich in fruits and vegetables, whole grains, and oily fish, is associated with  
21 reduced risk of cardiovascular disease and cancer. Social Cognition Models provide a basis for  
22 understanding the determinants of behaviour and are made up of behavioural constructs that  
23 interventions target to change dietary behaviour. The aim of this systematic review was to  
24 provide a comprehensive assessment of the effectiveness and use of psychological theory in  
25 dietary interventions that promote a whole dietary pattern.

26 **Methods:** We undertook a systematic review using the Preferred Reporting Items for  
27 Systematic Reviews and Meta-Analysis to synthesize quantitative research studies found in  
28 Embase, Medline, PsycInfo, CINAHL and Web of Science. The studies included were  
29 randomised and non-randomised trials published in English, involving the implementation of  
30 a whole dietary pattern using a Social Cognition Model to facilitate this. Two independent  
31 reviewers searched the articles and extracted data from the articles. The quality of the articles  
32 was evaluated using Black and Down quality checklist and Theory Coding Scheme.

33 **Results:** Nine intervention studies met the criteria for inclusion. Data from studies reporting  
34 on individual food group scores indicated that dietary scores improved for at least one food  
35 group. Overall, studies reported a moderate application of the theory coding scheme, with poor  
36 reporting on fidelity.

37 **Conclusion:** To our knowledge, this is the first review to investigate psychological theory  
38 driven interventions to promote whole dietary patterns. This review found mixed results for the

39 effectiveness of using psychological theory to promote whole dietary pattern consumption.  
40 However, the studies in this review scored mostly moderate on the theory coding scheme  
41 suggesting studies are not rigorously applying theory to intervention design. Few studies  
42 reported high on treatment fidelity, therefore, translation of research interventions into practice  
43 may further impact on effectiveness of intervention.. Further research is needed to identify  
44 which behaviour change theory and techniques are most salient in dietary interventions.

45 ***Key words:*** *Psychological theory, whole dietary patterns, theory coding scheme*

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## 48 **Background**

49 Major non communicable diseases (NCD) include, heart disease, stroke, cancer,  
50 diabetes, and chronic respiratory disease, and are estimated to represent 41 million deaths per  
51 annum globally [1]. According to the World Health Organisation (WHO, 2016) [1], a number  
52 of preventable risk factors underlie many NCD's and are the leading cause of death and  
53 disability globally regardless of economic status with one of the main risk factors considered  
54 to be poor diet attributable to 11 million deaths globally in 2017 [2]. Previously, the focus of  
55 research has been on single nutrients or single food groups, as the main disease states were due  
56 to nutritional deficiencies. However, the burden of disease has switched [2] to cancer, diabetes,  
57 and cardiovascular disease, due to demographic and epidemiological transitions, which are now  
58 the leading causes of death globally. This was partly due to a shift in the food environment,  
59 with people consuming more high-carbohydrate, low fat diets, which in turn lead people to  
60 consume more refined carbohydrates and refined sugar, which increases the risk of  
61 cardiometabolic diseases [3]. The dietary determinants of diseases such as cancer and diabetes  
62 are different from those of undernutrition and nutrient deficiency states [4]. Non-  
63 communicable diseases have multiple interacting dietary determinants consisting of either  
64 excess or insufficient intake, which cumulatively affect disease over time [5]. Therefore,  
65 research has gone beyond the single nutrient approach and focused on whole dietary patterns,  
66 which may be more beneficial to health due to the synergism between nutrients and food groups  
67 [6].

68 Improving dietary quality is not easily achieved. Healthy eating patterns revolve around  
69 regular consumption of a variety of foods from key food groups including cereal and cereal  
70 products, fruits and vegetables, meat and non-meat alternatives and dairy/non-dairy  
71 alternatives with the aim of optimizing nutrient intakes conducive to reducing the risk of  
72 chronic illness [7]. Globally between 1990-2010, consumption of healthy foods has increased,

73 however, the consumption of unhealthy foods had increased to a greater extent [8]. As opposed  
74 to a “healthy” dietary pattern , which can be nutrient based or only focus on certain aspects of  
75 a diet, for the purpose of this review, a whole dietary pattern is defined as the quantities,  
76 proportions, variety or combination of different foods in relation to the 5 foods groups of the  
77 Eatwell Guide, UK [9] and the MyPlate, USA [10] (fruit & vegetables, carbohydrates/grains,  
78 protein, fats & sugar, dairy products), or an established healthy eating pattern such as the  
79 Mediterranean diet [11].

80 It is clear, that interventions to promote adherence to a healthy dietary pattern are  
81 warranted. There is an array of research examining and evaluating the effectiveness of dietary  
82 interventions on chronic illnesses. There is some evidence in the literature to suggest, that the  
83 reporting of psychological theory use in behaviour change intervention development is  
84 associated with larger intervention effects [12]. Using psychological theory to design behaviour  
85 change interventions, provides a framework to accumulate evidence, test hypothesis, identify  
86 specific constructs that may influence behaviour and suggest which behaviour change  
87 techniques should be used in behavioural interventions [13].

88 Social Cognition Models (SCMs) (e.g. Theory of Planned Behaviour (TPB)) [14] are  
89 the most commonly used theories within the field of health psychology and behaviour change  
90 [15]. SCMs are useful for explaining, predicting, and understanding dietary behaviours, and in  
91 the design of dietary interventions to promote dietary change [16]. However, while SCMs has  
92 been used to predict dietary patterns [17,18], there is less evidence in the literature examining  
93 the effectiveness of interventions that use SCMs to promote whole dietary patterns, such as the  
94 Mediterranean [11], MIND [19], and DASH [20] diets. However, reviews in the literature show  
95 mixed results for the effectiveness of theory based dietary interventions. One meta-analysis  
96 found no association between dietary intervention effectiveness and theory use [21], while  
97 another meta-analysis on theory-based fruit and vegetable intervention among children, found

98 that after considering quality of studies, theory was associated with vegetable consumption  
99 only[22]. Furthermore, a previous review indicated that theory-based interventions were less  
100 effective than non-theory-based interventions [23].However, such research is held back by  
101 limitations in the extent to which interventions report on theory use, and insufficient  
102 descriptions of intervention content [24].

103         Some studies have been shown not to extensively use psychological theory in  
104 developing interventions [25]. One way to examine how theory has been applied to  
105 interventions is by applying the 19-item theory coding scheme (TCS) [26]. This scheme  
106 specifies whether theory is mentioned, whether theoretical constructs are targeted or measured,  
107 if theory was used to select recipients or to tailor the intervention and if theory was tested or  
108 refined. The TCS is a reliable tool to describe theory-based interventions; to inform evidence  
109 synthesis within reviews and has been used widely in systematic reviews to assess the  
110 effectiveness of theory and intervention effectiveness.

111         To advance behavioural research, improvement in methodologies are needed, with  
112 treatment fidelity proposed as a key area for improvement. Treatment fidelity refers to the  
113 processes used to ensure intervention components are delivered as intended [28]. To make valid  
114 interpretations regarding the efficacy of a behavioural intervention, it is important to provide  
115 details of treatment fidelity, which provides insights into the gap between theory and practice.  
116 To provide this information, specification of the intervention program is required. According  
117 to Bellg et al. [29], five domains to assess, monitor or enhance treatment fidelity have been  
118 identified by, as part of The National Institute of Health (NIH) and Behaviour Change  
119 Consortium (BCC), which are: (1) design of study, (2) training providers (3) delivery of  
120 treatment (4) receipt of treatment (5) enactment of treatment skills.

121 Previous systematic reviews have assessed the effectiveness of behavioural  
122 interventions on fruit and vegetable consumption [30], reduce sugar intake [31], or only  
123 reporting on dietary behaviours using one SCM, such as the Social Cognitive Theory [32]. One  
124 systematic review [32] aimed to identify effective dietary interventions for older people.  
125 However, this review examined both whole dietary patterns and single food groups such as  
126 fruit and vegetables. Furthermore, while this review reported the delivery of educational  
127 sessions, no theory was mentioned, or theoretical constructs reported. To our knowledge, the  
128 current review is the first to assess the effectiveness of SCMs in dietary interventions that use  
129 a “whole dietary pattern”. Therefore, the aim of this systematic review was to provide a  
130 comprehensive and systematic assessment of the effectiveness and use of SCMs in dietary  
131 interventions that promote “whole dietary patterns” in adults.

### 132 **Objectives:**

- 133 • To describe the extent of psychological theory in the design and implementation of  
134 dietary interventions to promote whole dietary patterns
- 135 • To evaluate the implementation of psychological theory in the design of dietary  
136 interventions to promote whole dietary patterns
- 137 • To determine the effectiveness of psychological theory based dietary interventions
- 138 • To explore the extent to which the fidelity of the intervention is monitored in these  
139 studies.
- 140 • To provide recommendations for future research to promote whole dietary patterns

### 141 **Methods**

142 The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) (see  
143 supplementary data file 1) [33] was used to inform the design, conduct and reporting of this  
144 systematic review. No ethical approval was sought as only secondary analysis of existing

145 datasets were involved in the study. The study protocol was registered with PROSPERO, the  
146 International Prospective Register of Systematic Reviews  
147 ([crd.york.ac.uk/prospero/index.asp?Identifier=CRD42017057366](http://crd.york.ac.uk/prospero/index.asp?Identifier=CRD42017057366)).

## 148 **Selection Criteria**

149 In accordance with PRISMA, the PICO (population, intervention, comparison, outcome, and  
150 study design) approach were used to formulate the selection criteria. (see Table 1).

151 Inclusion criteria: 1) study population: all adults aged 18 years or over; 2) study intervention:  
152 an intervention involving a “whole dietary pattern” such as the Mediterranean diet [11] Dash  
153 diet [18] and MIND diet [17] or foods analysed from at least 4 out of 5 of the food groups  
154 identified by the Eatwell Guide, UK (protein, grains/carbohydrates, oil and fats, dairy,  
155 fruit/vegetable; 3) psychological theory: studies were included that used a social cognition  
156 model to design their intervention (e.g. TPB); 4) study design: randomised controlled trials and  
157 , including single arm studies, and pilot studies published in English.

158 Exclusion criteria: 1) study population; studies targeting a population under 18 years old were  
159 excluded; 2) study intervention: studies were not included where the dietary behaviour was a  
160 de facto medical treatment e.g. gluten free diet. Also, studies analysing data from only single  
161 food group and nutrients, such as, fruit and vegetable, or omega 3 were excluded, as these do  
162 not constitute a “whole dietary pattern”; 3) psychological theory: studies that do not mention  
163 or report on a social cognition model were excluded; 4) study design: studies that were not  
164 interventions, such as qualitative or cross-sectional studies were excluded from this review.  
165 (see Table 1).

## 166 **Search Strategy and Study Identification**

167 Literature searches were conducted by (DT) between April 2019 and January 2020 using the  
168 following databases: EMBASE (1974-2020), Medline (1974-2020), PsycInfo (1974-2020),



169 CINAHL (1937-1-2020) and Web of Science (1950-2020). ProQuest Dissertations & Thesis  
170 was reviewed to locate unpublished studies and, reference lists of the selected studies for  
171 inclusion were searched manually. The following search terms were used in different  
172 combinations. Theoretical framework, behaviour change theory, Theory of Planned Behaviour,  
173 Theory of Reasoned Action, Health Belief Model, Self-determination Theory, Stages of  
174 Change Model, Health Action Process Approach, COM-B model, Social Cognitive Theory,  
175 Control Theory, Self-Efficacy Theory, Social Ecological Model, healthy eating, dietary  
176 intervention, dietary patterns, healthy eating, whole diets, Mediterranean, DASH and MIND  
177 diet were also chosen as search terms as these are “whole dietary patterns”, they do not  
178 eliminate any food group and promote a healthy lifestyle [7]. The studies were screened by the  
179 titles and abstracts. Studies that did not meet the inclusion criteria were excluded. Two  
180 researchers (DT&ES) reviewed the abstracts independently that were ambiguous for inclusion.  
181 Any disagreements were resolved through discussion with a third researcher (JM).

## 182 **Data Extraction.**

183 The following information was extracted from each study: author, design, country, quality  
184 score, participants characteristics, intervention, control, dietary pattern, theoretical model,  
185 outcome measures, main findings (Table 2).

## 186 **Methodological Quality**

187 The modified version of Downs and Blacks [34] quality checklist was used as some of the  
188 included studies were non-randomised studies. Question 27 was modified to “Did the study  
189 have sufficient power?” with one point awarded if a sample size calculation was completed  
190 [35]. Two researchers (DT&ES) independently assessed the quality of the studies. The Downs  
191 and Blacks quality checklist is considered a reliable and valid tool suitable for the use in random  
192 and non-random studies [36]. Studies were assessed on quality of reporting ( 10 questions;

193 partially = 1, no = 0 or yes = 2, or yes =1, no=0), external validity (3 questions; yes = 1, no =  
194 0,unable to determine = 0), internal validity – measurement bias (7questions; yes = 1, no = 0,  
195 unable to determine = 0), internal validity – selection bias (6 questions; yes = 1, no = 0, unable  
196 to determine = 0) and power (1 question ; yes = 1, no = 0, unable to determine = 0 ), equating  
197 to a total achievable score of 28 (see Table 3). Studies that scored less than 14 were considered  
198 poor, those that scored between 14-18 were considered fair, those that scored between 19-23  
199 were considered good and those scoring between 24-28 were considered excellent [37].

200 In addition to study quality being formally assessed, the Theory Coding Scheme (TCS)  
201 [26] was used to assess the extent to which theory was used to design behaviour change  
202 interventions within each study. The TCS consists of 19 items across 6 categories relating to;  
203 whether a theory was mentioned, if the relevant theoretical constructs are targeted, if theory  
204 was used to select participants and/or tailor interventions and if the relevant constructs were  
205 measured, if theory was tested and if theory was refined. Responses to all items with the  
206 exception of item 7 and 10 with a “yes” were given 1 point and those responded with a “no”  
207 and “don’t know” were given 0 points. Items 7 (All intervention techniques are explicitly linked  
208 to at least 1 theory-relevant construct) and 10 (All theory-relevant constructs are explicitly  
209 linked to at least 1 intervention technique) were given 2 points if the criteria were met (see  
210 Table 4). Similar scoring has previously been applied [38]. Similar to previous research using  
211 the TCS [39], this review scored each study as having a weak (0-7), moderate (8-15), or strong  
212 (16-23) use of theory. There was an initial 95% agreement of codes, which demonstrates an  
213 acceptable level of agreement. Discussion between researchers resolved any differences within  
214 the coding process.

215 Treatment fidelity

216 Treatment fidelity was assessed using a 29-item checklist [40] which mapped onto 5 domains  
217 identified by Bellg.[29] 1) treatment design (6 items); 2) treatment providers (7 items); 3)  
218 delivery of treatment (9 items); 4) receipt of treatment (5 items); enactment of treatment skills  
219 (2 items). The ability to draw solid conclusions from a study may be decreased, if any one of  
220 the domains lack consideration [40] (see Table 5).

## 221 **Results**

### 222 **Study Characteristic**

223 The basic characteristics of included studies are shown in Table 2.

#### 224 **Type of Studies.**

225 Nine studies met the inclusion criteria (see Figure 1). Seven of the included studies were RCT's  
226 [41-47] and 2 non-RCT's [48-49].

#### 227 **Type of Participants**

228 In all studies, participants had a mean age ranging from 34 to 72 years. Females represented  
229 between 45-100% of the overall sample. One study [43] did not state the number of males and  
230 females who participated. Six of the included studies had apparent healthy participants  
231 [41,42,45,47-49]. Three of the included studies had participants with a clinical diagnosis  
232 [43,44,46]. Of the nine studies, one was carried out in Australia [44], four in the USA  
233 [41,45,46,47], one in Canada [48], and three in the Mediterranean (Greece, Italy and  
234 Spain)[42,43,49].

#### 235 **Type of Dietary Pattern**

236 All studies included a whole dietary pattern that took into consideration the main food groups:  
237 protein, grains/carbohydrates, oil and fats, dairy, fruit/vegetable (n=9). Two of the nine studies  
238 specifically examined the Mediterranean diet [48,49], and one examined the DASH diet [46].

**239 Type of Primary Outcome.**

240 Outcome measures varied across studies. Two studies used the HEI-2005 to assess overall diet  
241 quality and adherence to the recommended diet [42,43], with higher scores representing better  
242 diet quality. One study assessed adherence to the Mediterranean diet with the Mediterranean  
243 Diet Adherence Screener (MEDAS) [49], with higher scores representing higher adherence to  
244 the Mediterranean diet. One study used the Diet Guidelines Index (DGI) to measure adherence  
245 to healthy recommendations over the previous month. A diet score is obtained with a range of  
246 0-150, with higher scores representing higher levels of healthy eating [44]. One study assessed  
247 dietary behaviour with a food frequency questionnaire [50] and compliance to USDA Food  
248 Pyramid [41,51]. One study used the AHEI-2010 to assess diet quality [45] with a total score  
249 between 0-110, with the higher score representing better diet quality. One study [48] assessed  
250 the level of adherence to the Mediterranean diet with a Medscore, which was calculated based  
251 on the food frequency questionnaire used in the study. Scores ranged from 0-44, with higher  
252 scores representing higher adherence to the Mediterranean diet. One study captured  
253 recommended foods by a 24-hour recall questionnaire and compliance with USDA Food  
254 Pyramid [47,51]. Finally, one study [46] used the Willett Food frequency Questionnaire [52] to  
255 derive a DASH adherence score, with a potential DASH score of 1-40 over 8 food components.  
256 Each component score between 1-5, with a higher score representing higher adherence.

**257 Quality of Studies.**

258 Out of a total score of 28, all 9 included studies scored between 15 and 25 on the Black and  
259 Downs quality assessment checklist (see Table 3), with one study scoring 25 which is  
260 considered excellent quality [45]. Four studies scored between 19-23 which is considered good  
261 quality [41,44,47,48], and the remaining four studies scoring between 14-18 which is  
262 considered fair quality [42,43,46,49]. Overall, the 9 included studies scored high on the first

263 subscale of the checklist (reporting). None of the included studies met the criteria for “external  
264 validity” subscale, with two studies scoring zero [42,43]. The following section is internal  
265 validity-bias which studies scored relatively high on this subsection with scores between 4-6  
266 out of a possible 7. The following subsection is internal validity-confounding (selection bias),  
267 which yielded the most variety of scores, which may be due to having different experimental  
268 designs. Only one of the RCTs [44] reported sufficiently on randomised intervention  
269 assignment concealment. Lastly, power to detect a significant effect was reported by 4 studies  
270 [41,45,47,48].

### 271 **Impact of intervention on dietary behaviour**

272 Two studies [48,49] examined the impact of a theory-based intervention on adherence to the  
273 Mediterranean diet. Both studies calculated an overall Medscore pre-post intervention,  
274 calculated from the Mediterranean Diet Adherence Screener (MEDAS) [49], or a food  
275 frequency questionnaire [48]. Both studies reported a significant increase in Medscore post  
276 intervention. One study [46] examined the impact of a tailored behavioural intervention (TBI)  
277 on adherence to the DASH diet, compared to a non-tailored intervention (NTI) and usual care  
278 (UC) group. At 6 months follow-up, TBI had a higher DASH score than UC and NTI. However,  
279 for individual components of the DASH diet such as fruit and vegetables, and wholegrains,  
280 there was no significant difference between groups on scores at 6-month follow-up. The  
281 remaining 6 studies examined individual components of dietary behaviours based on AHEI  
282 [45], HEI [42,43] DGI [44], FFQ [41] and 24hr recall/MyPyramid [47]. From these 6 studies,  
283 one study reported no improvement in dietary behaviour [44]. Only one study reported a  
284 significant improvement in fruit [45], vegetable intake [43], carbohydrates/grains [42] and dairy  
285 [42]. Two studies reported improvements in protein (fish, poultry, beans, meat, or eggs) [45,47]  
286 and total fats [41,42].

## 287 **Extent of theory use**

288 The extent to which theory was used within the selected studies was assessed using the TCS  
289 (Table 4) [26]. From the 9 included studies, the mean total TCS score across studies was 11,  
290 which is a moderate application of theory. One study [42] showed a weak application of theory,  
291 seven studies [41,43-45,47-49] were moderate, and one study showed a strong application of  
292 theory [46]. These scores suggest that theory had not been extensively applied to the design,  
293 implementation, and evaluation of behaviour change interventions, and/or theory use was  
294 reported with insufficient detail. These scores suggest that most studies are not explicitly  
295 reporting theory use in sufficient detail and/or fail to rigorously apply theory to intervention  
296 design and implementation. The following section describes the use of theory within the  
297 selected studies in terms of the 6 categories of coded items of the TCS [26]: (1) mention of  
298 theory; (2) targeting of theoretical constructs;(3) using theory to select recipients or tailor  
299 interventions; (4),measurement of constructs; (5) testing of mediation effects; (6) and refining  
300 theory.

### 301 ***Category 1: Mention of theory (Items 1-3)***

302 All studies (N=9) mentioned a theory (item 1, Table 4), with only 6 studies referring to theory  
303 as a predictor of behaviour and provided evidence of the association of the theory or theoretical  
304 construct and target behaviour. For example, one study using the Health Belief Model [41]  
305 stated that the best predictor of nutrition related behaviour change is the benefit-cost ratio, and  
306 for a change in nutrition behaviour to occur, the perceived benefits must outweigh the barriers.  
307 Out of the 9 studies, 7 were reported to be a single theory (item 3, Table 4) such as HAPA,  
308 SDT and TTM, while 2 studies combined theories (HBM and SCT).

### 309 ***Category 2: Are relevant constructs targeted (Item 5, 7-11)***

310 Eight of the studies used theory or predictors to select/develop intervention techniques (Item  
311 5, Table 4). Regarding linking intervention techniques to theoretical constructs, only 4 studies  
312 explicitly linked all intervention techniques to at least one theoretical construct (Item 7, Table  
313 4), with a further 5 studies linking at least one, but not all, intervention techniques to at least  
314 one theoretical construct (Item 8, Table 4). Three studies linked a group of techniques to a  
315 group of constructs (Item 9, Table 4). Only 4 studies explicitly linked all relevant theoretical  
316 constructs to at least one intervention technique (Item 10, Table 4), with a further 4 studies  
317 linking at least one, but not all, constructs with at least one technique (Item 11, Table 4). For  
318 example, one study [41] used the HBM to develop an educational intervention to improve  
319 dietary practices for CVD prevention. However, the intervention focused on perceived benefits  
320 and barriers and neglected other key concepts such as susceptibility and severity of illness,  
321 health motivation and perceived control. Another study [47] used the SCT model to develop a  
322 dietary intervention and focused their intervention techniques on self-regulation techniques,  
323 such as self-monitoring and goal setting, neglecting concepts such as outcome expectancy.  
324 Therefore, more than half (N=5) of these studies did not utilise the full predictive power of  
325 their chosen theory.

326 ***Category 3: Is theory to select participants or tailor interventions.***

327 None of the included studies used theory to select participants (Item 4, Table 4), and only 1  
328 study tailored intervention techniques to the participants. Therefore, the intervention differed  
329 for subgroups of participants that varied for a particular construct at baseline (Item 6, Table 4).  
330 This study was based on the TTM, and the intervention delivered to each participant varied  
331 depending on their stage of change at baseline.

332 ***Category 4: Are relevant constructs measured***

333 Seven of the studies reported measuring theoretical constructs pre-post intervention (Item 12,  
334 Table 4), and reporting on the validity and reliability of the scales used to measure  
335 constructs/predictors (Item 13, Table 4).

#### 336 ***Category 5: Testing theory***

337 Seven of the studies reported randomisation, two studies were non-RCTs (Item 14, Table 4).  
338 Four of the studies interventions changed the target theoretical constructs. For example, one  
339 study [41] using the HBM significantly increased perceived benefits of adoption of positive  
340 dietary behaviours and increased nutrition knowledge of CVD and cancer. Also, another study  
341 [45] reported that HAPA outcomes in the intervention group reported significantly greater  
342 frequency of action planning, and action and coping self-efficacy at follow-up (Item 15, Table  
343 4). Seven of the studies discussed the results in relation to theory (Item 16, Table 4) and three  
344 provided support for theory (Item 17, Table 4). That is, studies reported that constructs within  
345 the theory, significantly mediated the relationship between the intervention and outcomes. For  
346 example, one study [48] that used self-determination theory found that eating related self-  
347 determined motivation was associated with an increased adherence to the Mediterranean diet.

#### 348 ***Category 6: Refining theory***

349 Refining of theory, or suggestions for future refinement was not reported by any of the included  
350 studies (Item 18, Table 4).

#### 351 **Fidelity of interventions**

352 Of the 9 included studies, two studies included an assessment on all 5 domains [45,48]. One  
353 study included an assessment on only one domain [49]. Two studies included an assessment on  
354 two domains [41,42]. Three studies included an assessment on three domains [43,44,46]. One  
355 study included an assessment on four domains [47] (see Table 5).



356 *Study design*

357 All studies made an assessment on study design [41-49], with information about treatment dose  
358 provided in the intervention condition, and two providing information on treatment dose in the  
359 comparison group [45,47]. All studies reported underpinning theory [41-49]. No further trained  
360 providers were employed to allow for setbacks.

361 *Training providers*

362 Two studies provided information on training providers [45,48]. These studies provided  
363 information on how trainers were trained and standardisation of provider training. Strategies to  
364 enhance training providers included, using the same provider throughout the intervention [48],  
365 use of certified trainers [48], and train all providers together [45].

366 *Delivery of treatment*

367 Eight of the studies made at least one assessment on the delivery of treatment [41-48], which  
368 was assessed through direct observation of the intervention. Making sure that the interventions  
369 were delivered, and the appropriate dose given, being the most reported item in this domain.

370 Various criteria were used to evaluate the treatment delivery. For example, one study [47] used  
371 a checklist after each session to measure degree of adherence, and class attendance [42,47]. In  
372 another study, participants reported on the acceptability of the intervention [44], and how the  
373 participants rated the overall delivery of the intervention [48]. Other strategies used to assess  
374 delivery of treatment were the use of manuals to aid delivery [41,44-46].

375 *Receipt of treatment*

376 Six studies made at least one assessment on the receipt of treatment. Various strategies were  
377 used to assess receipt between authors and included ensuring that participants understood the  
378 intervention [43-48] and providing resources to enable participants to perform the behaviour

379 [47,48]. Other strategies to assess receipt of treatment included reviewing self-monitoring data  
380 [43,45], and assessing confidence in behavioural skills [44-47].

### 381 *Enactment of treatment skills*

382 Observation and practice of skills required within interventions were included in three of the  
383 studies. Observation of these skills in daily life were carried out in two of the studies [47,49].  
384 Other strategies to assess whether treatment was being enacted were daily self-monitoring and  
385 tracking devices [45].

386

## 387 **Discussion**

388 To our knowledge, this is the first systematic review to assess the effectiveness of  
389 dietary interventions promoting a whole dietary pattern using a social cognition model. This  
390 systematic review has investigated the extent of SCM use in designing interventions to increase  
391 adherence to whole dietary patterns and explored the associations between theory use and  
392 intervention effectiveness. This review also explored the extent to which the 5 domains of  
393 treatment fidelity are reported in the selected studies. We found that the overall scores, across  
394 the 9 included studies, measured by the TCS averaged 10 out of a possible 21 points. This  
395 suggests that the studies were not explicitly theoretically informed or used to their full extent,  
396 even though theory was explicitly mentioned. This review also found that only two studies  
397 made at least one assessment on all five fidelity domains. As all five components of fidelity  
398 are mutually exclusive. The validity of a study is potentially compromised with inattention to  
399 any one of the 5 fidelity domains [40].

400 Five behaviour change theories were used in the studies of the current review (HAPA,  
401 HBM, SCT, SDT, TTM), with HAPA used by 3 of the 9 included studies. Out of the 9 studies,

402 one study [44] showed no improvements in diet following the intervention based on the Diet  
403 Guidelines Index (DGI) to create an overall single score of diet quality. Previous research has  
404 stated that the way in which dietary scales score individual food groups to create a single score  
405 can be problematic [53], as observed associations could be due to single components rather  
406 than the overall dietary pattern [7]. Small-scale scores are less informative, as the extremes and  
407 the inherent characteristics of a pattern or a behaviour may not be fully captured [7].  
408 Furthermore, research has shown that participants had better control of their diet and ate more  
409 healthily compared to the general population and therefore, changes in diet quality could not  
410 be detected [44]. Also, those in the intervention group perceived less risk awareness to those  
411 in the control group, which could have affected their engagement in the intervention [44].  
412 Awareness of the importance of balanced nutrition is shown to be an important factor that may  
413 influence dietary choices [54,55].

414 Five of the studies used a dietary scale that reported individual food group scores. All  
415 five studies improved dietary scores for at least one food group. One study found a significant  
416 improvement in fruit intake [45], vegetable intake [43], carbohydrates/grains [42], and dairy  
417 [42]. Two studies reported improvements in protein (fish, poultry, beans, meat, or eggs)  
418 [45,47], and total fats [41,42]. These findings are consistent with a previous review which  
419 found that out of half the studies examined, at least one aspect of diet had not improved, with  
420 a further 5 studies showing no improvement in diet quality. However, in the same review, one  
421 quarter of the studies were found to be explicitly theoretically informed (based on the Theory  
422 Coding Scheme), and significantly improved diet quality. Of these 10 studies, 8 reported  
423 improvements in fruit and vegetables [25] suggesting that interventions that use behaviour  
424 change theory rigorously, lead to better outcomes in trials.

425 The current review found limited association between the use of psychological theory  
426 and improved intervention outcomes, with only three of the studies in this review reporting an

427 association between theory and intervention effectiveness (assessed through individual TCS  
428 items). One possible explanation for the relatively limited effectiveness of the interventions  
429 reviewed in the present review is that they apply theory insufficiently. The current review  
430 showed that the included studies revealed theoretical implementation weaknesses. Most  
431 notably, linking all BCTs to theoretical constructs were met by only 4 out of the 9 studies.  
432 Compared to previous findings [56,57], this review observed a closer link between intervention  
433 and theory, measured by a higher percentage of studies reporting on linkage between  
434 theoretical constructs and intervention techniques (TCS items 7-11). However, in the current  
435 review, only studies that explicitly mentioned theory were included. Previous research targeted  
436 interventions whether theory was mentioned or not for the target behaviour, with only half the  
437 studies reported to be explicitly based on theory, and of those, few targeted all theoretical  
438 constructs or linked all BCTs to theoretical constructs [57].

439 Theory based interventions can help us understand processes and effectiveness of  
440 interventions [26] by identifying key constructs that are shown to be related to behaviour and  
441 behaviour change techniques related to the relevant constructs, that can be used as a target for  
442 intervention design. Research has found that interventions tailored on theoretical concepts  
443 were more effective than those tailored on behaviour alone [58]. However, as more than half  
444 of the included studies in the current review did not report on this concept fully, the findings  
445 limit the extent of evidence of behaviour change factors [59]. Overall, these finding highlight  
446 the need for clearer selection, application, and reporting of theory use in the design,  
447 implementation, and evaluation of dietary intervention.

448 Linking BCT's to theory provides an opportunity to refine theory [26] and while the  
449 current review found that most of the studies linked at least one BCT to theoretical constructs,  
450 none of the studies used the results to refine theory. It is important to address this, as not only  
451 is theory important in the developmental stages of intervention design and future interventions,

452 but to the advancement of our understanding of how interventions affect behaviour. This lack  
453 of refining theory from interventions is common, with similar results found in recent research  
454 [59-61].

455 A second explanation to the relatively limited effectiveness of the interventions  
456 reviewed in the present review is that the interventions may not have been delivered as the  
457 designers intended. This cannot be ruled out, as treatment fidelity was poorly reported in the  
458 current review studies. According to Borrelli. [40] there are five domains of treatment fidelity:  
459 study design, training, delivery, receipt, and enactment, all of which are mutually exclusive.  
460 The validity of a study is potentially compromised with inattention to any one of the 5 fidelity  
461 domains. The overall reporting of treatment fidelity in the current review is poor, with only 3  
462 studies reporting on more than three of the five domains. This finding is similar to other reviews  
463 considering fidelity [40,62]. Overall, we found that regardless of the theory coding scheme  
464 score, those studies that reported high on fidelity, reported improvements in more food groups  
465 than those with lower fidelity. For example, one study [46] that scored the highest in the theory  
466 coding scheme but low on fidelity, reported a significant improvement in overall DASH score,  
467 but not in any of the individual food groups. Furthermore, two of the included studies that  
468 scored relatively low on the theory coding scheme and high on fidelity, reported better  
469 adherence to the Mediterranean diet [48], and improvement to several of the food groups  
470 including fruit, red meat, processed meat and total AHEI scores [45]. Moreover, two studies  
471 scoring the lowest on fidelity [41,42], reported improvements on less food groups, which did  
472 not include fruit or vegetables. However, these two studies also scored relatively low on the  
473 TCS. This finding demonstrates that, while the TCS addresses fidelity of treatment such as,  
474 explicitly identifying and use of theory as a basis for intervention design, there are other factors  
475 that are not addressed. For example, if insignificant results were found in an intervention and  
476 only one or two of the domains were of high fidelity, it is possible that the insignificant results

477 were due to a lack of attention in the other domains [28], such as the training providers may  
478 not have been adequately trained. Therefore, in order to enhance the transition from theory to  
479 practice, we recommend that intervention designers include a plan to assess and monitor  
480 treatment fidelity based on the 5 domains proposed by Borrelli [40].

481         Using theory to design behaviour change interventions have been criticised, as they  
482 specify what theoretical constructs (i.e. intentions) should be changed to change behaviour, but  
483 do not specify how constructs can be changed. However, systematic reviews have recently  
484 started to identify links between theoretical constructs and BCTs, enhancing the effectiveness  
485 of behaviour change interventions [63]. It has been suggested, those that target change  
486 mechanisms at population, community and individual levels are the most effective [64],  
487 suggesting that behaviour change interventions may benefit from drawing on a wider range of  
488 theories than Social Cognition Models [20]. Recently, new approaches to behaviour change,  
489 and the implementation and evaluation of interventions has been developed, in particular, the  
490 Behaviour Change Wheel, COM-B model and the BCT taxonomy which helps build the bridge  
491 between predicting behaviour and actual behaviour, by specifying the "active ingredients" of  
492 the intervention, and this classification will facilitate replication of interventions [65]. The  
493 Behaviour Change Wheel seeks to provide a framework, that other theories can be considered.  
494 Social Cognition Models constructs mainly fall into the reflective motivation component of the  
495 COM-B model and either minimally or not at all into the other 5 components [20]. The COM-  
496 B model is a holistic approach for changing behaviour, based on a model of an individual,  
497 rather than a mechanistic process of identifying determinants of behaviour based on factors  
498 accounting for variation in current behaviour between individuals [20]. The BCW incorporates  
499 the COM-B model, TDF and BCT's in a systematic approach in designing an intervention. The  
500 BCW is gaining popularity in developing interventions in a range of health behaviours  
501 including dietary behaviour [66,67]. Therefore, more research is needed, using new approaches

502 to understand dietary behaviour, and in the development and evaluation of complex  
503 interventions [68].

504

## 505 **Strengths and Limitations**

506

507 A major strength of the current review is the use of the TCS, which allowed for a deeper  
508 exploration of the extent of psychological theory driven interventions, and also our  
509 understanding of shortcomings in the reporting and implementation on the use of psychological  
510 theory. This review did not conduct a meta-analysis, however, the differences found in the  
511 included studies populations, interventions and behavioural theories would make the average  
512 effect across studies difficult to interpret [69]. Relevant studies may have been excluded due  
513 to selection criteria and search terms. For example, studies that are not in English but used  
514 theory and relevant to this review would be missed and studies that failed to report they used a  
515 behaviour change theory. However, full articles were obtained for possible inclusion for  
516 potentially relevant articles, even if theory was not explicitly mentioned in the abstract, further  
517 minimising potential bias. Coding of the TCS may be subject to misclassification bias,  
518 however, two researchers (DT&LS) interpreted and coded the TCS items to reduce any bias

## 519 **Conclusion**

520 To our knowledge this is the first review to examine psychological theory driven  
521 interventions that use a whole dietary pattern. We have found that, while all the included studies  
522 mentioned theory, total scores were mostly moderate, suggesting that theory had not been  
523 extensively applied to the design, implementation and evaluation of behaviour change  
524 interventions, and/or theory use was reported with insufficient detail. We recommend that  
525 future interventions explicitly link theory and outcome, to allow identification of the most

526 salient intervention techniques and behaviour change theory, to advance our understanding of  
527 behaviour change. To enhance the transition from theory to practice, we recommend  
528 researchers use a fidelity framework to guide the reporting of treatment fidelity in future  
529 research. Mixed results were observed for the effectiveness of theory-based interventions. With  
530 the small number of included studies, only one of which was high quality, findings should be  
531 interpreted with caution. Future reviews should include both theory and non-theory  
532 interventions, to provide evidence of the effectiveness of psychological based interventions  
533 compared to no theory use.

534

### 535 **Abbreviations**

536 BCC: Behaviour change consortium; BCT: Behaviour change techniques; COM-B: Capability  
537 opportunity, motivation and behaviour; CG: Control group; DASH: Dietary Approaches to  
538 Stop Hypertension; DGI: Dietary guidelines index; EPOC: Cochrane effective practice and  
539 organisation of care; HAPA: Health action process approach; HBM: Health belief model; HEI:  
540 Healthy eating index; IG: Intervention group; MEDAS: Mediterranean diet adherence screener;  
541 MIND: Mediterranean intervention for neurodegenerative delay; NCD: Non-communicable  
542 disease; PICOS: Population, intervention, comparison, outcome, study design; PRISMA:  
543 Preferred reporting items for systematic reviews and meta-analysis; PROSPERO: International  
544 prospective register of systematic reviews; RCT: Randomised controlled trial; SCT: Social  
545 cognitive theory; SDT: Social determination theory; TPB: Theory planned behaviour; TCS:  
546 Theory coding scheme; TTM: Transtheoretical model; USA: United states of America; USDA:  
547 Dietary guidelines for Americans; WHO: World health organisation.

548

### 549 **Declarations**



550 **Ethics Approval and Consent to participate**

551 Not applicable

552 **Consent for Publication**

553 Not applicable

554 **Availability of Data and Material**

555 All relevant data is included within the manuscript file

556 **Competing Interests.**

557 The authors declare they have no competing interests.

558 **Funding**

559 The Department for the Economy (DfE) sponsored the research for this paper.

560 **Authors Contributions**

561 DT/ LS designed the review and searched the databases for studies. DT/LS screened, quality  
562 assessed, and theory coded included studies. DT drafted the manuscript. LS, JMcC, MK, LK  
563 revised the manuscript critically for intellectual content. All authors read and approved the final  
564 manuscript

565 **Acknowledgment.** The authors would like to thank Dr Lynn Dunwoody and Joan Atkins for  
566 providing support and necessary information for the systematic review. No funding was  
567 provided for this systematic review.

568

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780 Figure 1: PRISMA flow chart identifying and screening studies, eligibility of studies and  
781 included studies n=9

782

783 **Supplementary information:**

784 Supplementary file 1: PRISMA 2009 checklist

785 The PRISMA 2009 checklist is a 27 item checklist for the reporting of a systematic review  
786 and/or meta-analysis, which include the title, abstract, methods, results, discussion, and  
787 funding.

788