

# 1 **Evaluating quality of implementation in physical activity interventions** 2 **based on theories of motivation: Current challenges and future** 3 **directions**

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5 The evidence base pointing towards the maladaptive health consequences of an  
6 inactive lifestyle highlights the need for interventions that are effective in  
7 changing and maintaining physical activity behaviours. Theories of motivation  
8 are frequently applied to inform the content and delivery of such interventions.  
9 Systematic monitoring and evaluation of the quality of intervention  
10 implementation is therefore an important step in understanding if and how  
11 theories of motivation can be adopted and effectively applied to promote and/or  
12 sustain physical activity behaviours. However, intervention implementation  
13 quality in studies that aim to apply motivation theory to promote physical activity  
14 is often under-reported. The purpose of this article is firstly to review  
15 contemporary approaches used to monitor and evaluate intervention  
16 implementation. We outline the degree to which these methods have been used  
17 effectively in research concerned with applying theories of motivation to impact  
18 physical activity behaviours. Secondly, we identify and discuss specific  
19 challenges in effectively measuring quality of implementation faced by  
20 researchers that adopt a motivation theory basis to their work. Finally,  
21 recommendations for methods to monitor and evaluate intervention  
22 implementation in future trials aiming to promote physical activity based on  
23 theories of motivation are also proposed.

24 **Keywords:** Fidelity; process evaluation; implementation; intervention; physical  
25 activity

26

27 There is strong evidence that physical inactivity is one of the leading causes of ill-health  
28 and premature death in Western societies (Kohl et al., 2012). However, despite these  
29 extreme health risks, physical inactivity remains a global health problem. Thus,  
30 identifying the most effective means to promote and sustain regular physical activity is

1 imperative for national governments and public health organisations to prevent chronic  
2 illness and promote good health. As a consequence, there has been a significant increase  
3 in studies that have developed and tested behavioural interventions designed to promote  
4 physical activity. Such work is often grounded in theories of motivation (Biddle,  
5 Mutrie, & Gorely, 2015; Rhodes & Dickau, 2012). Motivation has been identified as a  
6 key construct determining the intensity and direction of action in human behaviour.  
7 High quality motivation is purported to initiate, regulate, and sustain health behaviours  
8 (Deci & Ryan, 2000). Theories of motivation highlight the social-psychological  
9 antecedents of optimal and sustainable motivation for a targeted behaviour, such as  
10 physical activity. The inclusion of motivation theory in the development and testing of  
11 interventions aiming to change or maintain physical activity behaviours is, therefore,  
12 important (Conner & Norman, 2015; Michie et al., 2008). In this review we aim to  
13 evaluate contemporary approaches to the study of intervention implementation. We will  
14 discuss challenges and possible solutions associated with assessment and reporting of  
15 fidelity and quality of intervention implementation. We focus on studies that have  
16 adopted and applied theories and models of motivation derived from social psychology  
17 to inform intervention content. However, general issues relating to implementation  
18 quality are relevant to any type of intervention, irrespective of whether they are guided  
19 by motivational theory or not.

20         The development and testing of theory- and evidence-based behavioural  
21 interventions is an important step in translating evidence from intervention research to  
22 ‘real-world’ practice. The study of implementation efficacy in controlled settings may  
23 be useful for establishing the potential of an intervention to be effective. However,  
24 testing effectiveness in ‘real-world’ conditions potentially has more value in informing  
25 translation; an effective intervention must be able to operate within the contextual

1 constraints that would characterise the ‘real-world’ setting (Michie, 2008). Fidelity is  
2 more likely to be challenged in real-life settings due to the likely uncontrollability of  
3 external factors. It is, therefore, potentially even more critical that implementation is  
4 studied in these cases as the conclusions drawn from such interventions will only be  
5 valuable if the degree to which content and quality of delivery implemented during  
6 testing remains true to the intended design.

7         Nearly twenty years ago, Dane and Schneider (1998) reported that interventions  
8 that deviated most from the original design protocol were the least effective.  
9 Unfortunately the omission of assessment of implementation fidelity, or in other words,  
10 whether intervention delivery is consistent with the intended design (Dusenbury,  
11 Brannigan, Falco, & Hansen, 2003), is an on-going major methodological limitation in  
12 health promotion intervention research in the physical domain (Bellg et al., 2004;  
13 Marcus et al., 2006; Naylor et al., 2015).

14         Broadly speaking, physical activity intervention research based on theories of  
15 motivation aims to increase motivation in individuals to initiate and sustain health-  
16 related physical activity behaviour. This may be achieved using specific techniques and  
17 strategies linked to variables found to correlate with behaviour in formative research to  
18 motivate individuals to change their behaviour. There are a number of types of theories  
19 of motivation that have been used to understand physical activity behaviour and used as  
20 the basis for interventions. For example, interventions based on social cognitive theories  
21 such as social cognitive theory (Bandura, 1986) and the theory of planned behaviour  
22 (TPB; Ajzen, 1991), typically utilise persuasive techniques to manipulate individuals  
23 beliefs and attitudes with respect to the target behaviour. In the case of physical activity  
24 interventions, the TPB has been applied in clinical settings (Latimer, Ginis, & Arbour,  
25 2006) as well as non-clinical contexts such as schools (Chatzisarantis & Hagger, 2005),

1 and the workplace (Bardus, Blake, Lloyd, & Suzanne Suggs, 2014). Another theory  
2 derived from humanistic approaches to motivation, self-determination theory (SDT;  
3 Deci & Ryan, 1985, 2000), has tended to focus on influencing the style content and  
4 style of communication of social agents and significant others to facilitate physical  
5 activity participation, such as healthcare staff (e.g., Murray et al., 2015), exercise  
6 instructors (Ntoumanis, Thøgersen-Ntoumani, Quested, Hancox, 2016) and sport  
7 coaches (e.g., Duda et al., 2013). The aforementioned studies illustrate ways in which  
8 motivation theories have been adopted in intervention research to promote motivation  
9 toward physical activity behaviour. The advantage of adopting a theoretical basis to an  
10 intervention over an atheoretical or a theory ‘inspired’ approach is that it provides a  
11 framework for falsification and to systematically evaluate the processes and  
12 mechanisms responsible for change (Michie & Abraham, 2004). This enables  
13 intervention researchers to identify the key components of interventions that are  
14 effective in promoting motivation relative to those that lack effectiveness.

15         Although a theoretical underpinning is frequently advocated as essential in  
16 health behaviour intervention design (Craig et al., 2008), a significant number of  
17 physical activity interventions are atheoretical, or vary in the extent or way in which  
18 theory has been applied in design and effectiveness evaluation (Prestwich et al., 2014).  
19 Moreover, in studies that claim to be based on theory, the evidence supporting the  
20 assumed association with effectiveness is unclear (Prestwich et al., 2014). The specific  
21 ways that theory is utilised in intervention design and effectiveness testing may  
22 determine the degree to which one or more components from theory can improve the  
23 effectiveness of an intervention relative to the absence of those components. Without  
24 sufficient study of implementation processes it is difficult to identify exactly how  
25 theory-based components adopted in physical activity interventions are effective in

1 promoting motivation to promote engagement in physical activity behaviour. Moreover,  
2 the seldom reporting of how interventions are developed or the rationale that informed  
3 key decisions made in this process (Hoddinott, 2015) further inhibits any potential for  
4 identifying implementation-related moderators of intervention effectiveness.

5         The purpose of this paper is not to provide a review of intervention studies that  
6 have attempted to promote physical activity via applying theories and models of  
7 motivation. Rather, our goal is to highlight the importance of the assessment and  
8 reporting of fidelity and quality of intervention implementation in these studies with  
9 respect to their theoretical content. First, we outline the value of assessing intervention  
10 implementation and its component parts in theory-based intervention research in  
11 physical activity contexts. An overview of how implementation and associated terms  
12 are currently operationalised in the wider health promotion literature (beyond physical  
13 activity promotion), and the inconsistencies in this application, are discussed. Second,  
14 we highlight the challenges associated in studying intervention implementation in  
15 research drawing from theories and models of motivation. Finally, we offer some future  
16 research directions and recommendations. While we focus on physical activity  
17 interventions, we believe that the points raised have relevance to intervention research  
18 on health behaviours more broadly.

### 19 **Intervention Implementation in Physical Activity Promotion Research**

20         In a systematic review of 30 intervention studies designed to promote physical  
21 activity or dietary change, Greaves et al. (2011) reported none to assess the fidelity of  
22 the intervention. This finding highlights that fidelity is not considered a priority by  
23 authors and reviewers and its omission does not preclude publication of intervention  
24 results. The void in examining intervention implementation is not unique to studies

1 designed to promote physical activity and has been noted as a limitation in the wider  
2 health promotion literature (Marcus et al., 2006).

3         As a further illustration, we conducted a literature search of electronic databases  
4 (Scopus, Web of Science) in order to get a broad overview of the extent to which  
5 theory-based, motivation-focused physical activity intervention studies have reported in  
6 detail on the assessment and monitoring of implementation of theory in the testing of an  
7 intervention. We initially searched for articles that referred to ('physical activity' or  
8 'sport' or 'exercise' or 'PE' or 'Physical Education') and 'intervention' and  
9 'motivation' and 'theory' within the title, keywords or abstract. Our search returned 485  
10 articles. To further narrow the search to those studies that were or had included a  
11 detailed account of assessment and/or monitoring of implementation, we repeated the  
12 search and also specified 'intervention implementation' or 'feasibility' or 'fidelity' in  
13 addition to the aforementioned terms. This returned 24 articles. This illustration  
14 indicates that less than 5% of published work concerning interventions in the physical  
15 activity domain has provided a mention of intervention implementation and fidelity in  
16 the title, keywords or abstract. Other studies may have included examination of  
17 intervention implementation but not referred to it in the title, keyword or abstract.  
18 However, this point supports the argument that intervention implementation was not  
19 considered a *significant focus* in the majority of the identified studies.

20         We recognise that some studies that may not have come up in our search may  
21 still include a concise section detailing the study of implementation (e.g., Cohen,  
22 Morgan, Plotnikoff, Callister, & Lubans, 2015; Smith et al., 2014). In circumstances in  
23 which a detailed process evaluation is not feasible, this may be a reasonable  
24 compromise that would enable the reader to interpret the findings with necessary and  
25 relevant background information. However, our search highlights the limited number of

1 studies that dedicate major focus to the study of intervention implementation, relative to  
2 the overall number of trials utilising theories of motivation to inform physical activity  
3 interventions. There are numerous reasons why this may be the case and later in the  
4 paper we discuss a range of issues that may preclude researchers from evaluating, or  
5 editors from publishing, detailed accounts of the evaluation of intervention  
6 implementation.

## 7 **Terminology and Method in Intervention Implementation Research**

8         The study of intervention implementation involves continuous evaluation and  
9 monitoring of an intervention to identify the content delivered, how it is delivered, and  
10 the degree to which the content delivery is aligned with the intended design (Borrelli,  
11 2011; Dusenbury et al., 2003). Intervention implementation could be considered as a  
12 moderator of the effect of an intervention on outcomes. Hence, it is critical in  
13 explaining findings of intervention-based research (Moore et al., 2015). Evaluating  
14 intervention implementation also makes it possible to determine whether a null finding  
15 could be attributable to a poor quality intervention, or to poor or inconsistent quality in  
16 the delivery. The latter is known as ‘type III’ error (Basch & Gold, 1985; Dusenbury et  
17 al., 2003). It is, therefore, important to evaluate intervention implementation to ensure  
18 that high quality interventions with the potential to be effective are not disregarded on  
19 account of poor delivery.

20         A number of evaluation frameworks provide intervention researchers with a  
21 starting point around which to frame the study of implementation. These frameworks  
22 include approaches designed to assess and monitor implementation in trials of a wide  
23 range of public health interventions (e.g., RE-AIM; Glasgow, Vogt, & Boles, 1999).  
24 Frameworks have also been published that aim to better target certain types of  
25 intervention, such as those specifically targeting behaviour change (e.g., Borrelli, 2011).

1 Recently, Moore et al., (2014, 2015) have proposed means to address the problems of  
2 studying implementation in complex interventions (i.e., interventions with multiple  
3 interacting factors; Craig et al., 2008), which may be overlooked by other frameworks  
4 that do not inherently address interactions between different factors within or across  
5 levels of intervention. Each approach identifies specified ‘components’ that can be  
6 evaluated to ascertain quality of intervention implementation; interestingly, some  
7 common terms and themes can be identified across all three frameworks. Yet these  
8 frameworks also show diversity in how terms and themes are operationalised in relation  
9 to one another and in practice. Across these frameworks as well as the wider health  
10 promotion literature, there is a notable lack of consensus in the definition and  
11 operationalisation of terms related to the monitoring and evaluation of intervention  
12 implementation. This has resulted in diversity of opinions in what are considered to be  
13 the core components and the priorities in this process, as well as how it should be  
14 undertaken and reported. Moreover, inconsistencies in quality and consistency of term  
15 definitions precludes researchers from reliably comparing results or conducting meta-  
16 analyses (Naylor et al., 2015).

### 17 **The RE-AIM Framework**

18         The impediment on the overall progress of health promotion research caused by  
19 inconsistent language and methods in evaluating interventions was first raised by  
20 Glasgow et al. (1999). The RE-AIM (Reach, Effectiveness, Adoption, Implementation,  
21 and Maintenance) framework was originally published to in an attempt to address this  
22 issue of consistency. ‘Reach’ refers to the extent to which the target population are  
23 willing to engage in the intervention. ‘Effectiveness’ captures the degree to which the  
24 intervention has impacted upon the intended outcomes. ‘Adoption’ is defined as the  
25 proportion of the target population who are responsible for implementation and willing



1 to deliver the intervention. The quality and consistency of intervention delivery are  
2 captured within ‘implementation’. Finally, ‘maintenance’ refers to the degree to which  
3 the intervention is sustained over time, both at the individual or organisational levels.

4 The RE-AIM framework may be useful in evaluating some facets of  
5 implementation in certain theory-based public health interventions. For example, the  
6 TPB is often used to inform the content of health behaviour messages displayed in  
7 public places, such as stairwells at transport hubs (e.g., Lewis & Eves, 2012). RE-AIM  
8 could be utilised to inform evaluation of implementation in such interventions, via the  
9 recording of the number of passengers who pass through the station who read the  
10 message (reach), how many passengers who previously did not take the stairs changed  
11 their behaviour subsequent to reading the message (effectiveness), how many stations  
12 within a particular vicinity are willing to display the signage (adoption), to what extent  
13 the signage is adopted and displayed as intended by transport hubs (implementation),  
14 and how long the passengers continue to engage with the new behaviour (maintenance).  
15 While this application of RE-AIM would be informative as to the overall effectiveness  
16 of the intervention, it would not tease out whether the theory-based message content  
17 was effective in changing the passengers’ attitudes, perceived behavioural control or  
18 intentions, and whether it was one or more of these mediating mechanisms that led to  
19 changes in stair climbing behaviour.

20 When proposing RE-AIM, Glasgow and colleagues focused more specifically  
21 on implementation of an intervention over a minimum one-year period (Glasgow et al.,  
22 1999). It is also noteworthy that RE-AIM does not solely focus on intervention  
23 implementation. Originally the framework was intended as a model for intervention  
24 reporting, and more recently has been utilised to improve translation of research into  
25 practice once the effectiveness of the intervention has been supported. Since its

1 inception, RE-AIM has been applied across multiple intervention studies in the health  
2 promotion field with over 300 publications comprising applications or discussions  
3 concerning this framework currently listed on the RE-AIM website ([http://www.re-](http://www.re-aim.hnfe.vt.edu/publications/index.html)  
4 [aim.hnfe.vt.edu/publications/index.html](http://www.re-aim.hnfe.vt.edu/publications/index.html); accessed 05.11.2015).

## 5 **Borelli's (2011) Framework**

6         Since RE-AIM was proposed, other models and approaches to intervention  
7 implementation and evaluation have been developed. For example, Borrelli (2011)  
8 presented recommendations for best practice in treatment fidelity in relation to five key  
9 aspects. These are study design, provider training, treatment delivery (i.e., the extent to  
10 which the provider consistently delivered the treatment components (and not others)  
11 with the required skill level), treatment receipt (i.e. the degree to which the intervention  
12 was received by the participant as intended), and treatment enactment (i.e., whether the  
13 participant could enact the required cognitive and behavioural strategies and skills).  
14 Borrelli (2011) provide detailed tables listing strategies and recommendations as well as  
15 a checklist that can be used to assess fidelity of treatment. These include six  
16 considerations for treatment design (e.g., provide information about treatment dose),  
17 seven principles for training of providers (e.g., assessment and monitoring of provider  
18 skill maintenance over time), nine considerations **for delivery of treatment** (e.g., use of  
19 a treatment manual), **five recommendations for** receipt of treatment (e.g., multicultural  
20 factors considered in the development and delivery of the intervention), and **two**  
21 **criteria for the** enactment of treatment skills (e.g., a strategy will be used to assess the  
22 performance of the intervention skills in settings in which the intervention might be  
23 applied).

## 24 **The Application of Borrelli's (2011) Framework: A Motivational Interviewing** 25 **Example**

1           Borrelli's strategies could be adapted to assess intervention implementation in  
2 physical activity behaviour change studies. For example, researchers interested in the  
3 impact of a theory-based motivational interviewing (Miller & Rollnick, 2002)  
4 intervention on physical activity behaviour change in cardiac rehabilitation patients  
5 could enhance treatment fidelity at all of the study stages identified by Borrelli. At the  
6 design stage, pilot work incorporating scope for patient feedback could be used to  
7 identify the specific ways this communication style can be employed to motivate  
8 physical activity behaviours among cardiac patients. For example, how, when and  
9 where it would be appropriate for these patients to increase their physical activity  
10 behaviours would be influenced by their physical health status and so this may influence  
11 the types of changes the motivational interviewing process is guiding the patient  
12 towards. Those strategies that most appropriately exemplify the core components of  
13 motivational interviewing (i.e., engaging, evoking, increasing confidence, readiness and  
14 desire for change, and planning for action) and that should be evident in the intervention  
15 could be defined (Hardcastle, Fortier, Blake, & Hagger, 2016). The factors that may  
16 limit or alter the application of these communication techniques in a particular context  
17 (e.g., fear of another cardiac event, anxious spouse) could also be identified during  
18 piloting. Strategies to overcome such factors could be developed and incorporated into  
19 the intervention to improve acceptability and feasibility. Clear and specific scripting  
20 with context-specific examples could be created.

21           To date, many intervention studies grounded in motivational interviewing and  
22 other perspectives of motivation do not report how providers are trained and any  
23 attempts to improve fidelity via the training provided. The methods proposed by  
24 Borrelli (2011) to enhance fidelity of provider training would be applicable to training  
25 deliverers of motivational interviewing, as well as other motivation interventions, by

1 standardising training, increasing ‘buy in’ of providers, and preventing drift or decay in  
2 skills via ‘top up’ training and on-going feedback and mentoring. Better reporting of the  
3 provider training protocol in future studies would help to increase knowledge with  
4 regard to how much and exactly what type of training, mentoring and feedback is most  
5 efficacious. Borrelli makes some suggestions of generic strategies that could be  
6 employed to improve fidelity of delivery in a motivational interviewing intervention,  
7 such as provision of delivery manuals, on-going supervision to identify and correct  
8 mistakes in delivery, and determining ‘acceptable’ levels of competency for a provider  
9 to be considered sufficiently trained. Other strategies could be specifically customised  
10 to motivational interviewing. These could include coding audio and/or video footage of  
11 patient interactions to determine the frequency of use of certain strategies, such as using  
12 open-ended questions and providing positive affirmations. Coding tools could be  
13 developed that reflect the core components of motivational interviewing and context-  
14 specific applications of these strategies (Hardcastle et al., 2016).

15       Finally, Borrelli (2011) provides recommendations for enhancing fidelity of  
16 receipt of the intervention by the patient. The suggestions tend to work on the  
17 assumption that the intervention involves ‘upskilling’ the patients to engage in specific  
18 behaviours. In the case of cardiac rehabilitation patients, principles from motivational  
19 interviewing could be used to strengthen the potential impact of the proposed strategies.  
20 For example, while it is recommended that the intervention is based around  
21 achievement-related objectives, within a motivational interviewing intervention  
22 providers could be trained to ensure that the focus is on directing the patient towards  
23 setting their own physical activity-related objectives, reflecting the ‘patient-led’  
24 philosophy of motivational interviewing. In addition, aligned with Borrelli’s  
25 recommendations, interventionists could ensure that educational materials are engaging

1 and contextually and culturally appropriate, but the language and style in how the  
2 materials are presented could reflect the principles of motivational interviewing. Thus,  
3 instead of simply providing such information, motivational interviewing-focused  
4 materials could, for example, incorporate a series of questions that engage patients in  
5 continuing to evoke change-related cognitions and in turn, behaviours.

## 6 **Medical Research Council Guidelines**

7         The model by Borrelli (2011) centres on the issue of preserving fidelity across  
8 all of the five central domains, suggesting that fidelity is central to the process of  
9 effective implementation. Indeed, in the literature, the study of intervention fidelity is  
10 sometimes considered synonymous to undertaking a process evaluation (e.g., Robbins,  
11 Pfeiffer, Wesolek, & Lo, 2014). However, recent guidelines put forward by the UK  
12 Medical Research Council (Moore et al., 2015) refer to process evaluation as being a  
13 specific investigation that “aims to understand the functioning of an intervention, by  
14 examining implementation, mechanisms of impact, and contextual factors” (Moore et  
15 al., 2014, p. 8). Thus, according to this perspective, fidelity is only one aspect of  
16 implementation, which is only one component of a process evaluation. Implementation  
17 is defined as, “the process through which interventions are delivered, and what is  
18 delivered in practice” (Moore et al., 2014, p. 8). Examining fidelity is one important  
19 aspect of implementation but in isolation will not reveal a full picture of the  
20 implementation process. According to Moore et al. (2014), implementation also  
21 comprises the process (‘the structures, resources and mechanisms through which  
22 delivery is achieved’), adaptations (‘alterations made to an intervention in order to  
23 achieve better contextual fit’), dose (‘how much intervention is delivered’), and reach  
24 (‘the extent to which a target audience comes into contact with the intervention’) of an  
25 intervention. A high quality intervention would also demonstrate fidelity (i.e.,

1 remaining true to design) in relation to dose, adaptations and process, as well as  
2 intervention delivery. In other words, one might expect the designers to have specific  
3 targets in relation to these facets of implementation. As such, aspects of the Borrelli  
4 (2011), framework could be considered to be embedded within the Moore et al. (2015)  
5 model.

6 Moore et al. (2015) proposed that a comprehensive process evaluation should  
7 also incorporate assessment of the mechanisms of impact (i.e., how participants respond  
8 to the intervention, potential moderators and mediators), and the context in which the  
9 intervention is delivered (i.e., how contextual factors interact with how the intervention  
10 works), as well as the interplay between components of implementation, context and  
11 mechanisms. Collectively, these factors mediate the association between the  
12 intervention itself and its outcomes. Moore et al. (2015) have therefore facilitated the  
13 study of implementation of complex interventions as their approach also considers the  
14 potential impact of contextual and individual factors that may interact with  
15 implementation. We concur with Moore et al that without considering mechanisms of  
16 impact and the context in which the intervention is being delivered, evaluation of  
17 intervention implementation alone will not fully explain if and how an intervention  
18 relates to measured outcomes in a trial. It is also worth noting that many physical  
19 activity mediation analyses produce null findings (Lubans, Foster, & Biddle, 2008;  
20 Rhodes & Pfaeffli, 2010). However, the reporting of null findings is still important as  
21 such details can serve to inform the design and delivery of future intervention studies.

## 22 **Motivation-specific Challenges in Selecting an Appropriate Framework**

23 The thorough study of all components of even just the implementation aspect of  
24 a process evaluation, as defined by Moore and colleagues (2014, 2015) is a significant  
25 undertaking in itself. Therefore, although the most comprehensive assessment of

1 intervention implementation may be formed by undertaking a full process evaluation,  
2 such an evaluation is not always practical and is likely to be highly resource intensive.  
3 The diversity and complexity of intervention studies also demands that there is  
4 variability in the goals and methods of a process evaluation to suit each study (Moore et  
5 al., 2015). For example, in a study testing an intervention that targets the  
6 communication style of an exercise instructor to promote adaptive motivation among  
7 exercisers (e.g., Ntoumanis et al., 2016) it may be challenging to assess all features of  
8 implementation identified by Moore et al. (2015) or to apply the approaches to assess  
9 fidelity of treatment receipt and enactment, as defined by Borrelli (2011). This is  
10 because although the ‘treatment’ is ultimately targeting the quality of the physical  
11 activity-related motivation of the exerciser, the intervention itself is a communication  
12 skills education programme directed towards the exercise instructor. The instructor may  
13 be trained in specific skills to incorporate into his or her communication style, but at the  
14 exerciser level the hypothesised changes are cognitive or affective not behavioural, as  
15 the exerciser is already physically active. Changes in the instructor’s communication  
16 style may be subtle alterations to phrasing, body language, or class content and  
17 structure. This would be anticipated to have an overall impact upon the motivational  
18 environment in the exercise class. As such, there may be a change in quality, but not  
19 quantity of instructor behaviours. Thus, it becomes challenging to assess fidelity of  
20 receipt and enactment, or to assess ‘dose’ at the exerciser level. In this case then, the  
21 researcher may need to be selective in adopting the features of a process evaluation that  
22 make sense in the context of the underlying theory, participants targeted, and practical  
23 circumstances.

24 For example, in a self-determination theory-based intervention in a physical  
25 activity context, researchers may focus less on dose and reach, and more on assessment

1 of the degree to which what is delivered be consistent with the theory (i.e., exercisers  
2 are motivated in a manner that supports their autonomy, competence and relatedness).  
3 This could be evaluated via the use of observation scales to tap the need supportive  
4 features of the environment, and/or changes in participants' perceptions of their  
5 instructors' need supportive behaviours. Contextual factors that might impact the  
6 intervention delivery and effectiveness could include the size of exercise class, as it  
7 could affect the degree of individual interaction between each instructor and individual  
8 exerciser. Drawing from self-determination theory, mechanisms of impact of the  
9 intervention upon exercise behaviour would be expected to include the exerciser's  
10 degree of basic need satisfaction (i.e., feelings of autonomy, competence and  
11 relatedness in the exercise setting), and motivation regulations (i.e., reasons) for  
12 exercise. Pre- and post- assessments of these mechanisms would aid interpretation of  
13 intervention effects and the utility of the theory in explaining the outcomes.

14       If a full process evaluation is not possible or appropriate in the case of all  
15 interventions, a middle ground needs to be identified to determine a 'minimum  
16 acceptable' level of implementation evaluation. In the case of motivation-based  
17 intervention studies in the physical domain, it would be advantageous to identify which  
18 elements of implementation evaluation are most valuable in identifying effectiveness  
19 and efficacy of an intervention. This would be a worthwhile avenue for future research  
20 and may need to be a theory-specific endeavour. There have been recent calls for more  
21 detailed description of interventions, to facilitate replication and enable other  
22 researchers to build on existing findings. Checklists such as TIDierR (Hoffmann et al.,  
23 2014) and WIDER (Albrecht, Archibald, Arseneau, & Scott, 2013) should serve to  
24 improve the quality of intervention reporting which in turn will facilitate efforts to  
25 effectively evaluate intervention implementation.



1           Alongside highlighting the potential of several models of implementation when  
2 applied with different theories, this section has also highlighted the on-going variability  
3 in use of terminology. Key terms such as fidelity and implementation are used inter-  
4 changeably, or defined and related to one another in different ways across frameworks.  
5 Consequently, the aforementioned problem of inconsistency in use of terminology and  
6 methodology that led to the original development of RE-AIM has, in fact, been  
7 amplified. This variability in use of terminology creates significant challenges in  
8 identifying consistently effective and ineffective intervention features across a number  
9 of studies that have applied the same theory for the same purpose (e.g., the promotion of  
10 physical activity). From the perspective of physical activity promotion research, it may  
11 not be viable to propose a common framework to assess implementation as each  
12 framework offers something slightly different and so the appropriate choice will depend  
13 on the research question. However, the adoption of a common language of  
14 implementation would be an important first step in moving towards quality control and  
15 synergy in undertaking and reporting physical activity-related intervention studies.

### 16 **Challenges of Monitoring and Evaluating Intervention Implementation**

17           Many factors may contribute to the lack of emphasis on publishing  
18 implementation data in motivation-informed intervention research in physical activity  
19 settings. One important issue is that of intervention complexity. Traditionally,  
20 interventions designed to change physical activity focused on the provision of  
21 information, and neglected to consider whether the targeted individuals had the physical  
22 and psychological capacity to enact the targeted behaviour (Michie, van Stralen, &  
23 West, 2011). A growing body of research suggests that information alone is not  
24 sufficient to change behaviour (Hagger & Luszczynska, 2014). There is growing  
25 support for the notion that interventions must also ensure that the individual has the

1 psychological capacity, social and contextual opportunity but also critically, the  
2 motivation to initiate and sustain the targeted behaviour in the face of more attractive  
3 alternatives (Biddle et al., 2015). Correspondingly, interventions that aim to change  
4 physical activity behaviour are becoming increasingly complex. For example,  
5 interventions based on motivation theory aim to impact physical activity behaviour at  
6 the individual level (e.g., the newly signed up exercise participant) by changing the  
7 motivational style of salient social agents in the individuals' environment with whom  
8 they regularly interact (e.g., the exercise instructor). To be effective, the intervention  
9 should change and maximise not only the quality of the instruction provided, but also  
10 stimulate the social-psychological mechanisms known to initiate and regulate the  
11 individuals' physical activity behaviour (e.g., beliefs, habits) (Gardner, 2015; Rebar et  
12 al., 2016). This occurs amid a range of potential personal and contextual confounding or  
13 constraining factors (e.g., time, money, availability of facilities, self-efficacy, social  
14 support). Unfortunately the increased complexity of interventions can result in poor  
15 implementation (Young et al., 2008). This highlights the importance of evaluating  
16 implementation in the case of complex interventions; if a behaviour change intervention  
17 cannot be effectively delivered in practice then there is little value in pursuing the  
18 implementation.

19       Efforts to base interventions on theory may also lead researchers to lose sight of  
20 practicality and how such interventions might be adopted and applied in 'real world'  
21 situations. Adaptation of interventions to complement the needs and requirements of  
22 particular settings has been labelled 'pro-adaptation' and is an approach that has been  
23 held for many years (Berman & Mclaughlin, 1976). This practice is perhaps more  
24 relevant to circumstances in which research has an explicit aim to inform policy (Dane  
25 & Schneider, 1998). With the association between academic research and impact

1 becoming stronger, it is becoming increasingly important to ensure that interventions  
2 are sustainable beyond the end of the research project and can be employed by a range  
3 of individuals. Evaluating intervention implementation may, therefore, help the research  
4 team to identify which components are critical to retain and which are less so, during a  
5 process of pro-adaptation.

6 Many approaches to process evaluation adopt a ‘checklist’ design in which key  
7 components are expected to be evident for the intervention to be considered effective.  
8 For example, in the physical activity field, checklists of key components and/or  
9 observation sheets to record whether expected behaviours are evident are common tools  
10 described in the literature (Fortier, Duda, Guerin, & Teixeira, 2012; Robbins et al.,  
11 2014; Young et al., 2008). These checklists, as well as broader recommendations for  
12 checklists such as those of Borelli (2011), may be useful starting points for the design of  
13 a fidelity assessment. The popularity of this approach implies an assumption that to be  
14 efficacious, an intervention should have standardised and consistent components which  
15 can be measured to gauge fidelity, and subsequently and precisely replicated across  
16 deliveries by different providers or to different groups. However, we question whether  
17 all interventions should be designed to be delivered with 100% replication of specified  
18 criteria. For example, the efficacy of techniques such as motivational interviewing  
19 (Miller & Rollnick, 2002) require the significant other to be able to make ongoing  
20 judgements and adaptations to most appropriately respond to individual circumstances.  
21 As such, in many interventions perhaps there can be no exact ‘formula’ that will be  
22 effective in promoting autonomous, sustained and healthful engagement in physical  
23 activity.

24 An alternative perspective that may be appropriate for interventions based on  
25 theories of motivation is to define ‘minimal acceptable’ guidelines, or critical and non-

1 critical components (Bauman, Stein, & Ireys, 1991), and an effectively trained  
2 intervention practitioner can decide when it is appropriate or possible to deliver the  
3 most relevant components at the appropriate times. For example, an exercise instructor  
4 who does not use all possible strategies from a particular theory of motivation in an  
5 intervention will not necessarily be ineffective in providing an appropriate ‘dose’ of the  
6 intervention. He or she may determine which intervention components from the theory  
7 may be appropriate to include, and which components to exclude, based on experience  
8 and, importantly, the available evidence. Formative research is paramount in this regard,  
9 and an effectively trained practitioner will know how to use the evidence gained from  
10 research to inform the content of their interventions. As an example, consider an  
11 intervention based on self-determination theory (Deci & Ryan, 1985, 2000) aiming to  
12 train diabetes nurses to be autonomy supportive when presenting a new physical activity  
13 programme to patients. There may seem to be no reason for a nurse to use some features  
14 of an autonomy supportive style (e.g., provide a rationale for the activity) if working  
15 with an individual patient who has previously expressed his or her autonomous reasons  
16 for engaging in the proposed programme and fully endorses their own reasons for  
17 completing it. The nurse could still adopt a theoretically appropriate and supportive  
18 style and tone, and focus on helping the patient to have further input and decision  
19 making into creating the shape of their programme. This could be done in a manner that  
20 is optimally challenging and self-referenced, and with a style that emulates care, respect  
21 and promotes a sense of belonging. In this case, these would be the ‘critical  
22 components’ relevant to effectiveness of the intervention with this particular patient.  
23 The patient could leave with his or her psychological needs fully supported, but many  
24 components of autonomy supportive instructing, as specified in the theory, would not  
25 have been present in the intervention during this particular interaction.

1           The inadequacy of a ‘dose-response’ approach to understanding motivation has  
2 been highlighted in observational work based on self-determination theory (Smith et al.,  
3 2015). Consideration of the potency of the motivational climate created by the actions  
4 and inactions of a significant other is one recently adopted approach (Smith et al.,  
5 2015). From this perspective, what is considered more important is not the number of  
6 behaviours exhibited by a significant other, but their psychological meaning, in terms of  
7 the anticipated strength of the impact upon the basic needs of the individual. As we  
8 have highlighted previously, such considerations make it questionable as to whether it is  
9 possible to apply some aspects of ‘traditional’ models of implementation evaluation that  
10 refer to measuring ‘dose’ and ‘treatment’ (e.g., Borrelli, 2011). The language derived  
11 from medical and/or clinical settings implies that a ‘dose – response’ relationship is  
12 possible, and that ‘treatment’ can be standardised. Whether or not this is appropriate  
13 depends very much on the study design and targeted outcome. For example, drawing  
14 from the TPB (Ajzen, 1991) a researcher may consider whether delivery of a health-  
15 related message targeting behavioural intentions changes the amount of times an  
16 individual chooses to take the stairs over the lift. One could hypothesise that exposure to  
17 the message may relate to a quantifiable behavioural outcome (i.e., taking the stairs). As  
18 such, ‘dose’ can be easily quantified by controlling and measuring exposure to the  
19 message. However, when the researcher sets out to change the philosophical approach  
20 and behaviour of a rheumatoid arthritis nurse by training him/her to apply aspects of  
21 TPB to promote realistic intentions to exercise, assessing ‘dose’ becomes more  
22 problematic. Assessments of implementation in such cases need to be designed to  
23 operate effectively with the ebb and flow in correspondence with the reality of  
24 motivating individuals in social contexts.

## 25 **Future Research Directions**

1           One solution in attempting to capture the effectiveness of complex behaviour  
2 change interventions is to adopt correspondingly intricate models of process evaluation  
3 to capture the complexity and multi-component nature of behaviour change models  
4 (Baranowski & Jago, 2005). However, a thorough process evaluation that attempts to  
5 collect data via a range of methods and sources requires significant resource and is,  
6 perhaps for this reason, rarely accomplished. It remains the reality that even grant-  
7 funded physical activity behaviour change intervention studies rarely have surplus  
8 budget beyond what is needed for intervention delivery and measures of effect. As  
9 previously identified, some researchers manage this challenge by applying some but not  
10 all components of a process evaluation model. In the case of motivation-based physical  
11 activity promotion research, it would first be advantageous to establish which  
12 components of a theory or model should be prioritised as most relevant and useful in the  
13 study of intervention implementation.

14           Second, with an eye on balancing practicality with utility, it would be useful to  
15 empirically or otherwise substantiate how much information is enough information to  
16 make a clear judgement on quality of intervention implementation and its relevance for  
17 study outcomes. For example, coding of practitioners delivering an intervention is one  
18 of the more popular methods when evaluating quality of implementation. However, this  
19 may be unrealistic in terms of time required as well as intrusion of a researcher or  
20 camera being present when an intervention is delivered in naturalistic settings. Future  
21 research could serve the field well by examining whether there is a critical percentage  
22 or number of sessions that can be observed in order to get ‘sufficient’ assessment of the  
23 quality of implementation, without having to code every event yet still accounting for  
24 possible reactivity effects.

1           Decisions with regard to stipulating essential and non-essential critical  
2 ingredients will also impact upon the proposed analysis of intervention effects. If  
3 flexibility is to be adopted, it would be challenging to effectively implement per  
4 protocol analysis. In such cases, pilot work should be utilised to ascertain which  
5 components are critical and could be defined a priori, and which can be considered  
6 flexible. One might also argue that intention to treat analysis for physical activity  
7 behaviour change trials can offer valuable information regarding the pragmatic value of  
8 an intervention when delivered in ‘real-life’ settings.

9           Once intervention implementation data have been collected and condensed, the  
10 researchers must then decide how to analyse and report these findings. One option is to  
11 report findings independent of the main effectiveness paper, within a process evaluation  
12 type paper. This is advantageous in that it becomes possible to read a thorough and  
13 detailed account of the process evaluation, and to determine whether high fidelity was  
14 achieved. However, as proposed in the model put forward by Moore et al. (2015), the  
15 different facets of a process evaluation interact with one another, as well as with  
16 outcome measures of effectiveness. So if the implementation process is not considered  
17 in conjunction with study findings then it is difficult to determine how the quality of  
18 intervention consistency in intervention delivery may explain significant or null  
19 findings. If type III error is to be avoided, recommendations of how to incorporate  
20 process evaluation data into tests of intervention effects would be advantageous.

21           In studies targeting the behaviours or communication style of a significant other,  
22 it is important to consider whether their behaviours generate the type of social  
23 environment that is motivationally adaptive and supportive of physical activity levels.  
24 However, in understanding what has contributed to their effectiveness (or not), it is  
25 important too to evaluate the quality and consistency in the training of these individuals

1 to create the desired motivational environment. Variations in training may explain  
2 differences in implementation of the intervention. Often, this is overlooked in the  
3 reporting of studies, and could be potentially limiting, in terms of the future translation  
4 of findings into practice, or dissemination of effective training strategies between  
5 studies in different contexts. We call for researchers to be more explicit in reporting the  
6 training process implemented (and make use of online supplementary materials in  
7 journals, when such options exist), as well as examining the quality and consistency of  
8 implementation of this training. There is also the question of what constitutes ‘adequate’  
9 training to effectively deliver an intervention. This will require an understanding of the  
10 principles of the underlying theory on behalf of the trainee, as well as the ability to  
11 utilise these effectively using a range of strategies in expected and spontaneous  
12 scenarios. Future research might focus not only on the development of methods that can  
13 be used to upskill those whose behaviour we are trying to impact, but also to evaluate  
14 the quality of this training and their enactment of the targeted behaviours. Tools such as  
15 manuals, implementation guides, reflection, peer networks and mentoring can aid the  
16 quality of implementation and their use is commonly reported in the literature. The  
17 potential risk of ‘drift’ in quality of intervention delivery has previously been  
18 highlighted (Borrelli, 2011) and this may be partly attributable to disengagement with  
19 resources designed to keep the intervention on track. From the perspective of theories of  
20 motivation, to be effective and engaging, such methods and resources would need to be  
21 designed and implemented in such a way as to be motivationally adaptive. However,  
22 this consideration is rarely discussed or reported. Future research could also focus  
23 specifically on identifying the most efficacious design and use of intervention support  
24 resources and tools that pull from a particular theory which may enhance the



1 implementer's or end-user's sustained engagement with the resource throughout the  
2 intervention.

3         Such data has the potential to expose the weaknesses in the theory, as well as in  
4 the intervention itself. Unfortunately, such data are harder to publish and typically, not  
5 the outcome desired in reports of grant-funded research. Just as can be the case with  
6 study outcome data, intervention implementation data is also at risk of selective  
7 publication. In the long term, the quality of interventions will improve if more data were  
8 published on what did not work, and not just on what did. This perhaps leads to a call to  
9 journal editors to publish more null findings, when they are substantiated with concerted  
10 and detailed considerations of why an intervention did not work, as well as informed  
11 recommendations for a required change to improve effectiveness.

12

### 13 **Conclusion**

14         We have discussed the challenges faced by researchers who may wish to  
15 evaluate intervention implementation in motivation focused physical activity  
16 intervention studies. We have also outlined the diversity of approaches that have been  
17 adopted in the wider health promotion literature to undertake this task, the paucity of  
18 attention this topic has attracted in motivation-focused physical activity intervention  
19 studies, as well as the components of implementation that have been utilised in some  
20 investigations. We have raised some potential issues with the current diversity of  
21 definitions of key terms surrounding intervention implementation and called for  
22 movement towards a common interpretation and language. Finally, we have highlighted  
23 the potential limitations of translating some of these approaches into work grounded in  
24 theories of motivation, without due consideration of the epistemological and conceptual  
25 underpinnings of the intended intervention.

1           The social-psychological characteristics of many theories of motivation and the  
2 diversity of ways these theories are applied may make it impossible to create a ‘one size  
3 fits all’ method or model to evaluate intervention implementation. However, we propose  
4 that there are still further steps that could be taken to improve understanding of how  
5 theories of motivation can most effectively be applied to maximise the motivational  
6 environment in physical activity contexts, and in turn, promote physical activity  
7 behaviour change. These include moving towards a common language of  
8 implementation, studies to compare the efficacy of several models of implementation,  
9 and investigations to help develop guidelines for approaches to measurement of  
10 intervention implementation that remain ecologically valid and yet also practical in  
11 terms of time, resource and utility in analysis.

12           Theories of motivation have considerable potential to inform physical activity  
13 promotion efforts and this is reflected in the diversity of ways the theory is now applied  
14 in intervention studies targeting the behaviours of instructors, health professionals,  
15 teachers and sport coaches. The on-going development of approaches to evaluate and  
16 optimise intervention implementation in a manner that does not lose sight of the essence  
17 of the theory (or theories) will be critical to the development of interventions that are  
18 effective in promoting physical activity.

19

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