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Critical review of behaviour change techniques applied in intervention studies to improve cooking skills and food skills among adults

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Introduction

Cooking and food skills interventions have resulted in improved diet and health outcomes (Roberts and Barnard, 2005; Blake et al., 2011; Michie et al., 2011; McGowan et al., 2017; Oggioni et al., 2015; Vernarelli et al., 2015). However, there is a lack of clarity and understanding regarding the “active components” or discrete behavior change techniques used within these interventions (referred to as BCTs from this point onwards). Furthermore, there is limited understanding of how the design of cooking and food skills interventions impact on their effectiveness outcomes, as well as the role played by theoretical frameworks in promoting behavior change in this domain (Roberts and Barnard, 2005). This study defines cooking skills as “a set of mechanical or physical skills used in meal preparation” (McGowan et al., 2017); however, as domestic cooking involves broader, more complex processes, food skills should also include perceptual meal planning, food acquisition, organizational and creative skills, as well as those relating to nutrition and food hygiene (McGowan et al., 2017).

There is considerable evidence linking poor dietary intake with multiple chronic illnesses worldwide such as diabetes, cancer, and cardiovascular disease (McGowan et al., 2017; Oggioni et al., 2015; Vernarelli et al., 2015). The ability to cook and prepare meals from basic ingredients at home is posited and demonstrated as an integral component in the consumption of a healthy diet and diet quality (McGowan et al., 2017). Cooking and meal preparation have become increasingly important in Western countries where food consumption patterns have
changed (Blake et al., 2011) with family-centered mealtimes declining (Caraher et al., 1999), and lifestyles and workloads increasing, resulting in a decrease in domestic cooking skills, time spent in meal preparation, and an increase in fast food consumption (Mintel, 2012). Recent cross-sectional studies report a link between greater consumption of convenience and fast food and poorer health outcomes (Burgoine et al., 2014). In order to address these issues, as well as the escalating cost of health-related illnesses (Foresight, 2007), cooking and food skills interventions targeting dietary outcomes have grown in popularity within the public health sector (Caraher, 2012).

Michie et al. (2011) published a refined 40-item CALORE taxonomy (Michie et al., 2011) of BCT used to characterize the active components of inventions (e.g., barrier identification, goal setting and feedback on performance) to understand “what works” in a given circumstance, or within a particular population group, maximizing future intervention efficacy (Michie et al., 2009). In addition, a robust approach to “standardizing” behavioral interventions with regard to design, content, setting, and population group has been advocated by researchers to identify factors which lead to successful behavior change (Michie et al., 2009).

In light of the above this paper uses the CALORE taxonomy (Michie et al., 2011) to review existing cooking and food skills interventions to identify the BCTs employed. In addition, the study examined current cooking and food skills interventions in terms of their sample, theoretical underpinnings, design, and long-term and short-term outcomes.

Method search strategy

Cooking and food skills interventions were extracted from 2 worldwide systematic reviews, Reicks et al. (2014) and Reicks et al. (Under review). Both reviews were selected due to their recency, relevance, and robustness in design. Both systematic reviews (Reicks et al., 2014; Reicks et al., Under review) provided an international perspective on cooking skills and food skills interventions with adults. The first review (Reicks et al., 2014) identified relevant research published between January 1980 and December 2011. A total of 319 journal articles were identified (excluding duplicates) and screened which resulted in 25 studies meeting the inclusion criteria (discussed later). The second review (Reicks et al., Under review) identified relevant research between January 2012 and March 2016. A total of 2365 journal articles were identified (excluding duplicates) and screened which resulted in 34 studies meeting the inclusion criteria. Both review studies used the same keyword searches across three electronic databases (OVID MEDLINE, Agricola, and Web of Science) (please refer to original papers for more details).

Screening

Full text papers and reports which could not be accessed via online databases and web searches were provided by the author of the review papers and included in the present sample. All studies were screened by Reicks et al. (Reicks et al., 2014; Reicks et al., Under review) against the 6-point inclusion criteria detailed below. From both reviews, a total of 59 papers on community cooking and food skills interventions with adults were identified.

Eligibility

The eligibility of inclusion in the present study was as follows:

1. Population: focus on adults (18 years+).
2. Intervention: any that targeted the development of cooking skills/food skills with a hands on or demonstration/observation cooking component.
3. Outcomes: reported behavioral outcomes relevant to the intervention target i.e., health, dietary, and psychological outcomes.
6. Duplication: in cases with multiple publications on the same study (in this case the paper with the most comprehensive explanation of the methodology and results was used, e.g., Condrasky “Cook with a Chef” Intervention).

Data extraction

All studies were analyzed and the following information extracted: country, target population, sample size, intervention purpose, design, theoretical underpinnings informing the design of the intervention, primary and/or secondary outcomes (i.e., pre and/or post measures), and any reported long-term outcomes (i.e., post 3 months). Interventions were then coded using Michie et al.’s (2011) CALORE taxonomy (Michie et al., 2011) BCTs were mapped where identifiable according to cooking skills (i.e., the mechanical process of cooking, chopping, etc.) and food skills (i.e., perceptual planning, acquisition, organizational and creative skills, as well as those relating to nutritional knowledge and food hygiene).

On examination of specific BCTs within the CALORE taxonomy (Michie et al., 2011), certain definitions required further clarification and standardization to relate the taxonomy specifically to cooking and food skills interventions. To minimize any discrepancies surrounding inter-coder agreement in relation to the interpretation of each BCT, a codebook of definitions was discussed and agreed upon with two researchers involved in the coding process (DS and FL). In addition, the coders contacted the taxonomy authors for clarity over any discrepancies. For example, BCT #26 Prompt Practice explicitly states “prompt the person to rehearse and repeat the behavior or pre-paratory behaviors numerous times.” However, for the purposes of this study it was agreed (with the taxonomy authors) to extend the definition of this BCT to include the carrying out of a practical task relating to cooking skills or food skills even once (Michie et al., 2011). A third coder (LH) reviewed all interventions and codes to ensure consistency.

Data analysis

Each research paper was read several times to gain a full understanding of the nature of the intervention. A deductive coding approach was applied using the taxonomy (Michie et al., 2011) to identify the total number of BCTs within each intervention.
The methodology and results of each paper were scrutinized and the CALO-RE framework was applied. Each BCT was then inspected for overlap and to ensure that the correct classification was made. The papers were independently coded by the first researcher (DS) who previously had undergone BCT coding training. To ensure inter-coder reliability, a sample of approximately 50% of interventions were independently coded by FL, then 10% of the full sample coded by a third researcher (LH). BCT outcomes were subsequently cross-mapped between coders and any discrepancies were discussed and reconciled. Results were collated and summarized so that the intervention outcomes could be compared with specific BCTs or combinations of BCTs identified (see Table 1).

Results

Overall, the results displayed some commonalities among the interventions relating to intervention design, BCTs used, and theoretical underpinnings reported.

Intervention design

A total of 59 cooking and food skills interventions were included within the present study and are summarized in Table 1. Overall, 24 interventions included mainly practical cooking sessions to develop cooking skills and 35 interventions focused on wider food skills issues, to include promoting nutritional knowledge, accessing healthy ingredients, and budgeting as a means to change dietary behavior with some cooking skills teaching. Of the 59 interventions included in this study, 31 were conducted in the United States (McMurry et al., 1991; Auld and Fulton, 1995; Hermann et al., 2000; Levy and Auld, 2004; Brown and Hermann, 2005; Chapman-Novakofski and Karduck, 2005; Newman et al., 2005; Woodson et al., 2005; Lacey, 2007; Shankar et al., 2007; Swindle et al., 2007; Clifford et al., 2009; Brown and Richards, 2010; Condrasky et al., 2010; Hanson et al., 2011; Wunderlich et al., 2011; Archuleta et al., 2012; Carmody et al., 2012; Francis, 2012; Bielamowicz et al., 2013; Condrasky et al., 2013; Flynn et al., 2013; Rustad and Smith, 2013; Goheer et al., 2014; Hearst et al., 2014; May et al., 2014; Mayfield and Graves, 2014; Peters et al., 2014; Adam et al., 2015; Anderson et al., 2015; Greenlee et al., 2015), 6 in the United Kingdom (McKellar et al., 2007; Wrieden et al., 2007; Kennedy et al., 2008; Davies et al., 2009; Penn et al., 2013; Garcia et al., 2014), 5 in Australia (Foley and Pollard, 1998; Abbott et al., 2010; Michie et al., 2011; Herbert et al., 2014; Hossain et al., 2015), 4 in Canada (Flesher et al., 2011; Sorensen et al., 2011; Archuleta et al., 2012; Dasgupta et al., 2012), 3 in Scandinavia (Karvetti, 1981; Pluss et al., 2011; Vadstrup et al., 2011), 2 in Japan (Kitaoka et al., 2013; Kwon et al., 2015), 2 in Italy (Dasgupta et al., 2012), and 1 each in China (Chung and Chung, 2014), India (Balagopal et al., 2012), Indonesia (Fahmida et al., 2015), South America (Jacoby et al., 1994), Netherlands (Poelman et al., 2015), and the Republic of Ireland (McGorrian et al., 2015).

Of the 59 intervention designs, 12 were randomized controlled trials (RC) (Karvetti, 1981; Levy and Auld, 2004; Clifford et al., 2009; Flesher et al., 2011; Pluss et al., 2011; Sorensen et al., 2011; Carmody et al., 2012; Peters et al., 2014; Greenlee et al., 2015; Kwon et al., 2015; Poelman et al., 2015; McGorrian et al., 2015), 12 were non-randomized controlled trials (NRC) (Jacoby et al., 1994; Auld and Fulton, 1995; McKellar et al., 2007; Wrieden et al., 2007; Kennedy et al., 2008; Archuleta et al., 2012; Balagopal et al., 2012; Bielamowicz et al., 2013; Kitaoka et al., 2013; Chung and Chung, 2014; Adam et al., 2015; Anderson et al., 2015), and the remaining 35 studies were pre/post or only evaluations only. Sample sizes ranged from 21 participants to 7422 participants with a mean of 359 participants. The target population for each intervention varied and was coded into 5 main groups: 16 interventions targeted low-income and vulnerable groups (e.g., the elderly) (Jacoby et al., 1994; Auld and Fulton, 1995; Ranson, 1995; Foley and Pollard, 1998; Keller et al., 2004; Swindle et al., 2007; Wrieden et al., 2007; Kennedy et al., 2008; Hanson et al., 2011; Flynn et al., 2013; Rustad and Smith, 2013; Chung and Chung, 2014; Garcia et al., 2014; Anderson et al., 2015; Hossain et al., 2015; Kwon et al., 2015); 20 interventions targeted groups with health needs (e.g., recovering cancer patients or “cancer survivors”) (Karvetti, 1981; Hermann et al., 2000; Chapman-Novakofski and Karduck, 2005; Newman et al., 2005; McKellar et al., 2007; Flesher et al., 2011; Pluss et al., 2011; Sorensen et al., 2011; Vadstrup et al., 2011; Archuleta et al., 2012; Carmody et al., 2012; Dasgupta et al., 2012; Villarini et al., 2013; Bielamowicz et al., 2013; Kitaoka et al., 2013; Penn et al., 2013; Greenlee et al., 2015; McGorrian et al., 2015; Poelman et al., 2015; Villarini et al., 2015); 14 interventions targeted the general adult population (including students) (Hermann et al., 2000; Levy and Auld, 2004; Brown and Hermann, 2005; Lacey, 2007; Clifford et al., 2009; Brown and Richards, 2010; Wunderlich et al., 2011; Balagopal et al., 2012; Francis, 2012; Goheer et al., 2014; Herbert et al., 2014; Peters et al., 2014; Adam et al., 2015); 6 interventions targeted specific cultural groups (e.g., Aboriginal adults) (Woodson et al., 2005; Shankar et al., 2007; Davies et al., 2009; Abbott et al., 2010; Condrasky et al., 2013; Hearst et al., 2014); and 3 interventions targeted families (Condrasky et al., 2010; Mayfield and Graves, 2014; Fahmida et al., 2015). Of the 59 interventions, 40 interventions recruited a mixed gender sample, 14 interventions recruited a female only sample, and 5 interventions recruited a male only sample (see Table 1).

With regard to intervention duration, 6 included only 1 session (Jacoby et al., 1994; Lacey, 2007; Brown and Richards, 2010; Condrasky et al., 2013; Mayfield and Graves, 2014; Poelman et al., 2015); 13 interventions ran between 2 and 4 sessions (Ranson, 1995; Foley and Pollard, 1998; Levy and Auld, 2004; Chapman-Novakofski and Karduck, 2005; Clifford et al., 2009; Pluss et al., 2011; Vadstrup et al., 2011; Archuleta et al., 2012; Francie, 2012; Bielamowicz et al., 2013; Rustad and Smith, 2013; Chung and Chung, 2014; Hearst et al., 2014); 17 interventions included 5-7 sessions (McMurry et al., 1991; Auld and Fulton, 1995; Woodson et al., 2005; McKellar et al., 2007; Shankar et al., 2007; Swindle et al., 2007; Wrieden et al., 2007; Condrasky et al., 2010; Hanson et al., 2011; Kitaoka et al., 2013; May et al., 2014; Goheer et al., 2014; Adam et al., 2015; Fahmida et al., 2015; McGorrian et al., 2015; Villarini et al., 2015); 10 interventions included between 8 and 10 sessions (Hermann et al., 2000; Keller et al., 2004; Brown and
### Table 1. Summary of cooking intervention outcomes.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Country</th>
<th>Method</th>
<th>Sample Size</th>
<th>Target Pop.</th>
<th>Gender</th>
<th>Number of Sessions</th>
<th>Type</th>
<th>Aim</th>
<th>Results Reported</th>
<th>Outcomes</th>
<th>Positive Short- Term Effects</th>
<th>Positive Long Term Effects</th>
<th>Theory Explicit in the Study Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown and Richards (2010)</td>
<td>US</td>
<td>Pre/post</td>
<td>616</td>
<td>General pop.</td>
<td>Mixed</td>
<td>1</td>
<td>CS</td>
<td>To increase variety of meals</td>
<td>1</td>
<td>3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Lacey (2007)</td>
<td>US</td>
<td>Post</td>
<td>55</td>
<td>General pop.</td>
<td>Female</td>
<td>1</td>
<td>CS</td>
<td>To introduce a range of cereal products</td>
<td>1</td>
<td>3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>none</td>
</tr>
<tr>
<td>Abbott et al. (2010)</td>
<td>AUS</td>
<td>Post</td>
<td>23</td>
<td>Cultural group</td>
<td>Mixed</td>
<td>29</td>
<td>FS</td>
<td>To apply NK and FS to daily lives and the wider family</td>
<td>2</td>
<td>2.3</td>
<td>No 1 D</td>
<td>2</td>
<td>none</td>
</tr>
<tr>
<td>Davies et al. (2009)</td>
<td>UK</td>
<td>Pre/post</td>
<td>46</td>
<td>Cultural group</td>
<td>Mixed</td>
<td>28</td>
<td>FS</td>
<td>To engage Asian groups to healthy eating practices</td>
<td>3</td>
<td>3</td>
<td>Yes 1 D 2 D</td>
<td>1</td>
<td>none</td>
</tr>
<tr>
<td>Swindle et al. (2007)</td>
<td>US</td>
<td>Pre/post</td>
<td>53</td>
<td>Low-income &amp; vulnerable groups</td>
<td>Mixed</td>
<td>6</td>
<td>FS</td>
<td>Measure the impact of “eating right”</td>
<td>1</td>
<td>3</td>
<td>Yes 1 D</td>
<td>1</td>
<td>EL</td>
</tr>
<tr>
<td>Shankare et al. (2007)</td>
<td>US</td>
<td>Pre/post</td>
<td>212</td>
<td>Cultural group</td>
<td>Female</td>
<td>6</td>
<td>FS</td>
<td>Increase FV consumption among African American women</td>
<td>1</td>
<td>2.3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>SET</td>
</tr>
<tr>
<td>Newman et al. (2005)</td>
<td>US</td>
<td>Pre/post</td>
<td>739</td>
<td>Health needs</td>
<td>Female</td>
<td>12</td>
<td>FS</td>
<td>To introduce plant based foods</td>
<td>1</td>
<td>2</td>
<td>Yes 1 D</td>
<td>1</td>
<td>SCT</td>
</tr>
<tr>
<td>Woodson et al. (2005)</td>
<td>US</td>
<td>Pre/post</td>
<td>485</td>
<td>Cultural group</td>
<td>Mixed</td>
<td>6</td>
<td>FS</td>
<td>Promotion of nutritional info</td>
<td>1</td>
<td>3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>none</td>
</tr>
<tr>
<td>Brown and Hermann (2005)</td>
<td>US</td>
<td>Pre/post</td>
<td>602</td>
<td>General pop.</td>
<td>Mixed</td>
<td>8</td>
<td>FS</td>
<td>Increase FV in young adults</td>
<td>1</td>
<td>2</td>
<td>Yes 1 D</td>
<td>1</td>
<td>none</td>
</tr>
<tr>
<td>Keller et al. (2004)</td>
<td>CAN</td>
<td>Pre/post</td>
<td>29</td>
<td>Low-income &amp; vulnerable groups</td>
<td>Male</td>
<td>8</td>
<td>CS</td>
<td>Increase nutritional well-being of older males</td>
<td>3</td>
<td>3</td>
<td>Yes 1 D</td>
<td>1</td>
<td>none</td>
</tr>
<tr>
<td>Foley and Pollard (1998)</td>
<td>AUS</td>
<td>Pre/post</td>
<td>612</td>
<td>Low-income &amp; vulnerable groups</td>
<td>Mixed</td>
<td>4</td>
<td>FS</td>
<td>Reduce cost of healthy household shopping</td>
<td>1</td>
<td>2.3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>none</td>
</tr>
<tr>
<td>Ranson (1999)</td>
<td>AUS</td>
<td>Pre/post</td>
<td>60</td>
<td>General pop.</td>
<td>Male</td>
<td>4</td>
<td>CS</td>
<td>Promote cooking confidence in men</td>
<td>3</td>
<td>3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>none</td>
</tr>
<tr>
<td>Chapman-Novakofski and Karduck (2005)</td>
<td>US</td>
<td>Pre/post</td>
<td>239</td>
<td>Health needs</td>
<td>Mixed</td>
<td>3</td>
<td>NK</td>
<td>Increase food choices to those with diabetes</td>
<td>1</td>
<td>3</td>
<td>Yes 1 D</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Hermann et al. (2000)</td>
<td>US</td>
<td>Pre/post</td>
<td>76</td>
<td>General pop.</td>
<td>Mixed</td>
<td>8</td>
<td>CS</td>
<td>Promote nutritional education in food choices and cooking</td>
<td>1</td>
<td>1.2</td>
<td>Yes 1 D</td>
<td>2</td>
<td>SCT</td>
</tr>
<tr>
<td>McMurry et al. (1991)</td>
<td>US</td>
<td>Pre/post</td>
<td>336</td>
<td>Health needs</td>
<td>Mixed</td>
<td>6</td>
<td>FS</td>
<td>Promote nutritional information and its application</td>
<td>1</td>
<td>3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>none</td>
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<tr>
<td>Condasky et al. (2010)</td>
<td>US</td>
<td>Pre/Post</td>
<td>29</td>
<td>Family</td>
<td>Mixed</td>
<td>6</td>
<td>CS</td>
<td>Formative analysis of the “Cooking with a Chef” project</td>
<td>3</td>
<td>3</td>
<td>Yes 1 D</td>
<td>2</td>
<td>SCT</td>
</tr>
<tr>
<td>Wrieden et al. (2007)</td>
<td>UK</td>
<td>NRC</td>
<td>113</td>
<td>Low-income &amp; vulnerable groups</td>
<td>Mixed</td>
<td>7</td>
<td>CS</td>
<td>Using “Cookwell” to promote healthy eating</td>
<td>2</td>
<td>3</td>
<td>Yes 1 D</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Study</td>
<td>Location</td>
<td>Type</td>
<td>Sample</td>
<td>Gender</td>
<td>Age</td>
<td>Intervention</td>
<td>N</td>
<td>Scale</td>
<td>Notes</td>
<td></td>
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<tr>
<td>Kennedy et al. (2008)</td>
<td>UK</td>
<td>NRC</td>
<td>26</td>
<td>Female</td>
<td>10</td>
<td>Increase NK of domestic food practices</td>
<td>3</td>
<td>2,3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>none</td>
<td></td>
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<td>Auld and Fulton (1995)</td>
<td>US</td>
<td>NRC</td>
<td>29</td>
<td>Female</td>
<td>5</td>
<td>Increase the use of commodity foods</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>SLT</td>
<td></td>
</tr>
<tr>
<td>Jacoby et al. (1994)</td>
<td>S Am</td>
<td>NRC</td>
<td>143</td>
<td>Female</td>
<td>1</td>
<td>Improve awareness of food preparation practices in terms of weaning</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>none</td>
<td></td>
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<tr>
<td>McKellar et al. (2007)</td>
<td>UK</td>
<td>NRC</td>
<td>130</td>
<td>Female</td>
<td>6</td>
<td>Investigate the impact of a Mediterranean style diet on patients with arthritis</td>
<td>1</td>
<td>1,2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>none</td>
<td></td>
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<tr>
<td>Clifford et al. (2009)</td>
<td>US</td>
<td>RC</td>
<td>101</td>
<td>General pop.</td>
<td>4</td>
<td>FS</td>
<td>Assess the impact of TV cooking shows on cooking motivation &amp; learning</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>SCT</td>
</tr>
<tr>
<td>Levy and Auld (2004)</td>
<td>US</td>
<td>RC</td>
<td>65</td>
<td>General pop.</td>
<td>4</td>
<td>CS</td>
<td>Determine if cooking sessions improve knowledge attitudes, efficacy, and behavior</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>SLT</td>
</tr>
<tr>
<td>Karvetti (1981)</td>
<td>SCD</td>
<td>RC</td>
<td>272</td>
<td>Health needs</td>
<td>Male</td>
<td>15</td>
<td>Assess the benefit of cooking dem. on NK &amp; self-efficacy</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>none</td>
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<tr>
<td>Flesher et al. (2011)</td>
<td>CAN</td>
<td>RC</td>
<td>40</td>
<td>Health needs</td>
<td>Mixed</td>
<td>17</td>
<td>Measure the impact/individual nutritional advice, cooking and exercise classes vs standard care</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>none</td>
</tr>
<tr>
<td>Adam et al. (2015)</td>
<td>US</td>
<td>NRC</td>
<td>7422</td>
<td>General pop.</td>
<td>5</td>
<td>CS</td>
<td>Online course/cooking instruction to improve eating behavior</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<td>Do cooking classes to improve nutrient intake in people with type 2diabetes</td>
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<td>Improve Glycemic and blood pressure</td>
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<td>Improve food purchases and eatinghabits</td>
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<td>Study the pattern of dietary change following a cooking skills class</td>
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Key:
- AUS: Australia
- CAN: Canada
- INSA: Indonesia
- NL: Netherlands
- ROI: Republic of Ireland
- SAM: South America
- SCD: Scandinavia
- SLT: Social learning theory
- SMT: Social marketing theory
- SET: Social ecology theory
BCTs identified across interventions

BCTs were identifiable in all 59 studies; employing between 1 and 11 of the 40 BCTs, though none explicitly reported intervention techniques as "BCTs." Thirteen interventions incorporated less than 4 BCTs (McMurry et al., 1991; Lacey, 2007; Brown and Richards, 2010; Hanson et al., 2011; Pluss et al., 2011; Archuleta et al., 2012; Villarini et al., 2012; Herbert et al., 2014; Adam et al., 2015; Anderson et al., 2015; Hossain et al., 2015; Kwon et al., 2015; Villarini et al., 2015); 21 interventions included 4–6 BCTs (McMurry et al., 1991; Foley and Pollard, 1998; Levy and Auld, 2004; McKellar et al., 2007; Shankar et al., 2007; Swindle et al., 2007; Wrieden et al., 2007; Condresky et al., 2010; Sorensen et al., 2011; Vadstrup et al., 2011; Wunderlich et al., 2011; Dasgupta et al., 2012; Bielamowicz et al., 2013; Flynn et al., 2013; Kitaoka et al., 2013; Chung and Chung, 2014; Garcia et al., 2014; Hearst et al., 2014; Mayfield and Graves, 2014; McGorrian et al., 2015; Poelman et al., 2015); 21 interventions between 7 and 10 BCTs (Jacoby et al., 1994; Auld and Fulton, 1995; Ranson, 1995; Keller et al., 2004; Chapman-Novakofski and Karduck, 2005; Newman et al., 2005; Woodson et al., 2005; Kennedy et al., 2008; Clifford et al., 2009; Pluss et al., 2011; Balagopal et al., 2012; Carmody et al., 2012; Francis, 2012; Condresky et al., 2013; Penn et al., 2013; Rustad and Smith, 2013; Goheer et al., 2014; Peters et al., 2014; Anderson et al., 2015; Fahmida et al., 2015; Greenlee et al., 2015); and three interventions incorporated 11 BCTs (Karvetti, 1981; Brown and Hermann, 2005; Flesher et al., 2011). The following BCTs were not used because they were not applicable to the cooking skills interventions chosen for this analysis: BCTs #3, 14, 25, and 31–40. As illustrated in Figure 1, the top 6 BCTs most frequently used across the 59 interventions were (in descending order): BCT#1 Provide information on consequences of behavior in general.

Many interventions applied general information such as nutritional education to meet the needs of the individual. For example, the "Eating Right" intervention promotes the instructor’s role as facilitating experiences to meet the needs of the learner and their prior experiences (Woodson et al., 2005). BCT#21 Provide instruction on how to perform the behavior was the second highest ranking BCT identified. Many of the practical cooking interventions used recipes and methods which could realistically be replicated in the home setting, e.g., in offering advice on inexpensive ingredient which may be sourced easily within participants own communities (Brown and Hermann, 2005; Newman et al., 2005). Thirdly, BCT#26 Prompt practice, e.g., prompting individuals and groups to take part in practical cooking sessions. Fourthly, BCT#22 Model or demonstrate the behavior, where cooking group facilitators may demonstrate a cooking method to promote learning. BCTs #20 and #2 jointly ranked in fifth place. BCT#20 Provide information on where and when to perform the behavior. In addition to offering information on how to carry out food skills, these interventions suggested where to carry out the behavior. This was illustrated in the "Food Cent$" sessions advise participants how to carry out food skills and where to access inexpensive ingredients (Keller et al., 2004). BCT#2 Provide information on consequences of behavior to the individual; e.g., during the "Cookwell Programme" (Wrieden et al., 2007), participants were offered nutritional information, to include the consequences of excess saturated fat and sugar on their personal diet and lifestyle. Lastly BCT #8 Identify barriers/problem solving where participants were encouraged to consider barriers to behavioral change then problem solve to overcome issues preventing behavioral change (see Figure 1). The "Friends with Food Programme" (Kennedy et al., 2008) was a nutritional education program which encouraged a sample of low income women to plan and prepare familiar family meals. Following sessions on nutrition and healthy eating, a problem solving discussion was facilitated on what pre- vents individuals from cooking healthy meals at home as well as considering ways in which barriers such as financial restrictions could be overcome.
Each intervention contained 1–11 BCTs (mean 7.4 BCTs; mode 5 BCTs) aimed to promote behavior change (see Table 2). Across the interventions, BCTs #1 and #2 related to information provision commonly appeared together (23 out of 59 interventions). BCT#1 related to providing general information on the consequences of the behavior, whereas BCT#2 extended this by providing information on the consequences of the behavior specifically related to the individual, i.e., tailored or personally relevant information.

It was also common for BCT#20 and BCT#21 to be used together with an intervention (21 out of 59 studies), where BCT#20 was related to informing on where and when to perform a behavior and BCT#21 was based on providing instruction on how to perform a behavior. In 30 of the studies, BCT#26 Prompt practice accompanied BCT#21. In nine of the interventions BCT#22 Model or demon-strate the behavior also accompanied BCT#20 and BCT#21.

Of the 59 interventions, 55 reported positive outcomes at the close of the intervention or in the short-term (i.e., within 3 months) (All interventions except for Abbott et al., 2010; Vadstrup et al., 2011; McGorrian et al., 2015; Villarini et al., 2015). The studies measured behavior change in terms of health outcomes, dietary outcomes, and psychological outcomes. Of the studies, 18 identified short-term behavioral change in relation to health (e.g., reduced cholesterol) (Hermann et al., 2000; McKellar et al., 2007; Pluss et al., 2011; Sorensen et al., 2011; Wunderlich et al., 2011; Archuleta et al., 2012; Balagopal et al., 2012; Carmody et al., 2012; Francis, 2012; Dągupta et al., 2012; Villarini et al., 2012; Flynn et al., 2013; Penn et al., 2013; Chung and Chung, 2014; Anderson et al., 2015; Fahmida et al., 2015; McGorrian et al., 2015; Poelman et al., 2015), 26 in relation to dietary outcomes (e.g., improved nutritional intake) (Auld and Fulton, 1995; Foley and Pollard, 1998; Hermann et al., 2000; Brown and Hermann, 2005; Newman et al., 2005; McKellar et al., 2007; Shankar et al., 2007; Kennedy et al., 2008; Abbott et al., 2010; Hanson et al., 2011; Wunderlich et al., 2011; Archuleta et al., 2012; Balagopal et al., 2012; Carmody et al., 2012; Bielamowicz et al., 2013; Penn et al., 2013; Rustad and Smith, 2013; Garcia et al., 2014; Goheer et al., 2014; Hearst et al., 2014; Herbert et al., 2014; May et al., 2014; Fahmida et al., 2015; Greenlee et al., 2015; Hossain et al., 2015; Poelman et al., 2015), and 40 in relation to psychological change (e.g., improved nutritional knowledge) (Karvetti, 1981; McMurry et al., 1991; Jacoby et al., 1994; Ranson, 1995; Foley and Pollard, 1998; Keller et al., 2004; Levy and Auld, 2004; Chapman-Novakofski and Karduck, 2005; Woodson et al., 2005; Lacey, 2007; Shankar et al., 2007; Swindle et al., 2007; Wrieden et al., 2007; Kennedy et al., 2008; Clifford et al., 2009; Davies et al., 2009; Abbott et al., 2010; Brown and Richards, 2010; Condral et al., 2010; Flesher et al., 2011; Vadstrup et al., 2011; Archuleta et al., 2012; Balagopal et al., 2012; Carmody et al., 2012; Francis, 2012; Bielamowicz et al., 2013; Condral et al., 2013; Kitaoka et al., 2013; Rustad and Smith, 2013; Chung and Chung, 2014; Garcia et al., 2014; Goheer et al., 2014; Herbert et al., 2014; May et al., 2014; Mayfield and Graves, 2014; Adam et al., 2015; Anderson et al., 2015; Fahmida et al., 2015; Hossain et al., 2015; Kwon et al., 2015). Long-term positive outcomes (greater than 3 months) were reported in 14 of the 59 interventions (Keller et al., 2004; Brown and Hermann, 2005; Newman et al., 2005; Swindle et al., 2007; Davies et al., 2009; Pluss et al., 2011; Francis, 2012; Flynn et al., 2013; Penn et al., 2013; Garcia et al., 2014; Herbert et al., 2014; Peters et al., 2014; Greenlee et al., 2015; Hossain et al., 2015). Fifty-six interventions contained BCT#1 (information on the consequences of the behavior in general); and BCT#26 (prompt practice). Table 2 illustrates the BCTs identified within each intervention and highlights short- and long-term outcomes.

For the 14 interventions reporting long-term successful outcomes (based on health, dietary and health outcomes), half (n = 7) were conducted in the United States, 3 in the United Kingdom, 2 in Australia, 1 in Indonesia, and 1 in Canada. Samples were of mixed gender for the majority of studies though males exclusively participated in 5 studies. The target population for each of these interventions varied, with no discernible pattern, e.g., some were drawn from the general population, some from specific cultural groups, some low-income and vulnerable groups, and some with specific health needs. The 14 studies stating long-term positive outcomes contained between 4 and 28 cooking sessions with the most common BCTs reported being BCT#26 Prompt practice, and BCT#21 Informa-tion on how to perform the behavior, appearing in 10 out of the 14 studies. The BCT#1 Providing general information on the consequences of the behavior was evident in 9 of the studies; and BCT#20 Relating to information on where and when to perform a behavior was used in 4 of the studies. BCT#2 Providing information on the consequences of the behavior specifically related to the individual. Table 2 highlights the differences between the BCTs which feature more prominently in interventions where long-term outcomes are reported, in comparison to the 59 interventions overall. Table 2 illustrates that practical cooking experience is important in promoting behavioral change rather than watching cooking skill demonstrations that only model behavior and provide direction on how to carry out the skills.

### Theoretical underpinning of interventions

Theory was explicitly cited in 14 of the 59 interventions (Auld and Fulton, 1995; Hermann et al., 2000; Levy and Auld, 2004).

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**Table 2.** Comparison between the percentage of most commonly occurring BCTs in all 59 interventions and 14 reporting long-term behavioral change.

<table>
<thead>
<tr>
<th>Behavioral Component Technique</th>
<th>Percentage of all 59 Interventions</th>
<th>Percentage of 14 Interventions Where Reporting Long-Term Behavioral Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - General Information giving</td>
<td>98</td>
<td>64</td>
</tr>
<tr>
<td>2 – Information giving specific to the individual</td>
<td>41</td>
<td>21</td>
</tr>
<tr>
<td>20 - Where and when to carry out the task</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>21 - How to carry out the task</td>
<td>76</td>
<td>71</td>
</tr>
<tr>
<td>22 - Demonstrate the task</td>
<td>66</td>
<td>0</td>
</tr>
<tr>
<td>26 - Prompt practice/practical cooking</td>
<td>44</td>
<td>71</td>
</tr>
</tbody>
</table>
Chapman-Novakofski and Karduck, 2005; Newman et al., 2005; Shankar et al., 2007; Swindle et al., 2007; Clifford et al., 2009; Brown and Richards, 2010; Condrasky et al., 2010; Archuleta et al., 2012; Francis, 2012; Condrasky et al., 2013; Adam et al., 2015). However, none of these papers reported how the chosen theory was used in the selection of the specific BCTs employed in the intervention, and no study linked the theory to the content or outcomes. Of the 14 interventions citing a theoretical framework in the intervention development, 9 cited Social Cognitive Theory (SCT) (Hermann et al., 2000; Chapman-Novakofski and Karduck, 2005; Newman et al., 2005; Clifford et al., 2009; Brown and Richards, 2010; Condrasky et al., 2010; Archuleta et al., 2012; Condrasky et al., 2013; Adam et al., 2015). 2 cited Social Learning Theory (SLT) (Auld and Fulton, 1995; Levy and Auld, 2004); 1 cited Experiential Learning Theory (Swindle et al., 2007); 1 discussed Social Ecological Theory (Shankar et al., 2007); and 1 Social Market- ing Theory (Francis, 2012). BCT#22 Model or demonstrate the behavior was identified in 12 out of the 14 (All except Swindle et al., 2007; Condrasky et al., 2010) interventions citing explicitly a theoretical framework in the methodology. BCT#26 Prompt practice was identified in 7 of the 14 theory-based inter- ventions. Of these 7 interventions, 6 involved BCT#22 and BCT#26 together (All except Condrasky et al., 2010). There did not appear to be systematic differences in BCTs identified from explicitly theory-based interventions versus those interventions which did not state a theoretical framework in the design. Of the 14 studies which used theory in the intervention design, all indicated that primary outcomes were met and reported positive short-term gains (i.e., within 3 months). Only 3 out of the 14 studies reporting the use of theory in the design showed long-term positive outcomes (greater than 3 months) (experi- en- tial learning theory (Swindle et al., 2007); social ecological theory (Newman et al., 2005); social marketing theory (Francis, 2012)) whilst 11 of the studies (Keller et al., 2004; Brown and Her- mann, 2005; Davies et al., 2009; Pluss et al., 2011; Flynn et al., 2013; Penn et al., 2013; Garcia et al., 2014; Herbert et al., 2014; Peters et al., 2014; Greenlee et al., 2015; Hossain et al., 2015) which reported no theory, evidenced long-term positive outcomes. Therefore, no pattern was identified between theory-based interventions, positive long-term outcomes and inclusion of specific BCTs or combinations of BCTs.

Discussion

This study identified and reviewed 59 cooking and food skills interventions in relation to intervention design, identifiable BCTs, theoretical underpinnings, and study outcomes. A more standardized approach with thought given to the theoretical framework underpinning behavioral change may be more likely to promote consistency in the planning of BCTs used and the success of the intervention so that comparisons can be made.

Less than half of the 59 interventions included in this study, contained practical or “hands on” food preparation or cooking elements (coded as BCT#26 Prompt practice) as the main focus of the intervention. However, of those interventions reporting long-term behavioral change, the majority included a practical skills element (BCT#26). Those interventions involving cooking demonstration only (BCT#22) reported no long-term behavioral change. It may therefore be surmised that to increase the success rate of cooking interventions and maintain behavioral change in the long term, it is important to empower participants to become involved in practical hands on cooking sessions.

The majority of the interventions (55 out of 59) involved populations in developed countries (31 studies in the United States, 6 studies in the United Kingdom, 4 in Canada, 3 in Scandinavia, 2 in Italy, 2 in Japan, 1 in the Netherlands, and 1 in the Republic of Ireland). Therefore, the results must be considered separately from those involving culturally disparate populations (e.g., South America, China, India, and Indonesia) as replication of the same interven- tion within a different context may not yield similar results. The majority of interventions targeted vulnerable groups or those with health needs.

The majority of interventions identified between 4 and 10 BCTs which, focus on behavior change related to providing information, or instruction and practice. Furthermore, BCT#1 (information on the consequences of the behavior in general), BCT#21 (instruction on how to perform the behavior) and BCT#26 (prompt practice) appeared across all interventions that were deemed successful in the long term. Furthermore, BCT#2 (information on the consequences of the behavior tailored to the individual), and BCT#20 (information on when and where to perform the behavior) were used in at least half of these successful interventions. Therefore, these BCTs should be used in the future design, planning, and delivery of robust and effective cooking and food skills interventions to promote behavior change.

In addition, the most common BCTs used were related to providing information on the consequences of a behavior generally (BCT#1). Many interventions utilized general informa- tion-giving strategies such as providing nutritional education. Previous research has shown that knowledge is required as a basis to generate creativity and the application of skills (Cho et al., 2013), therefore this information sharing can be consid- ered an important constituent of cooking and food skills inter- ventions. However, it is also generally accepted among behavioral science that information alone is not sufficient to change behavior (Campbell et al., 1994). A more holistic set of knowledge and skills related to nutrition, planning meals, food acquisition, and social interaction is required for individuals to change their eating behavior and develop skills in preparing healthy home cooked meals.

In the majority of the interventions where general informa- tion (#BCT1) was provided on the relationship between the behavior and its likely consequences, e.g., how a diet high in fats or salt or sugar (HFSS), #BCT2 was also present because the information was tailored to the specific needs of the groups. Such information tailoring can be argued to have a greater impact upon individuals, by increasing personal relevance, thus making behavior change more likely (Michie and Abraham, 2004; Michie et al., 2008).

BCT#26 Prompt practice was featured in 39 interventions and captured those instances of carrying out a practical activity (e.g., food preparation/cooking), thereby offering an essential form of skills development in the cooking and food skills domain. Studies in which social learning theory was present
revealed the common use of (BCT#22) demonstration of cooking and food skills interventions from across the globe (Reicks et al., 2014; Reicks et al., Under review). We are confident that given the recency and robustness of these studies, this critique of cooking and food skills interventions has included a representative sample of interventions. The review benefited from the input of coders who were experienced in the use of BCTs and intervention development and had undertaken extensive training online in advance using the BCT Taxonomy v1 program available from http://www.bct-taxonomy.com. In addition, it was possible to contact the authors of the taxonomy to seek clarification around any BCT classifications, where there was disparity between coders or ambiguity around taxonomy-override wording such as for BCT#26 Prompt practice which provided rigor to the BCT mapping exercise.

The 40-item CALO-RE taxonomy (Michie et al., 2011) was utilized in this study, however an updated 23-item taxonomy is available (Roberts and Barnard, 2005). The 23-item taxonomy may be suitable for use in offering a more detailed breakdown of a lesser number of studies which potentially may offer a more prescriptive conclusion in terms of effective BCTs for future cooking skills interventions. The BCTs discussed here are based upon the written information which was available in the articles or reports retrieved, and it is possible that additional BCTs were involved in the interventions which were not adequately described in the published reports. However, given the discernible patterns of BCTs identified across multiple and global cooking and food skills interventions, we can be somewhat reassured that the findings indeed reflect the true intervention content. Similarly, in relation to theory, only 14 of the 59 interventions reported explicitly following a theoretical framework in the design of the intervention; yet none discussed this explicitly in terms of their selection of intervention strategies or BCTs. It is possible that theory was employed in the design and selection of other interventions but was not reported, which could lead us to underestimate the true impact of behavior change interventions. It is also worth noting that none of the BCTs identified across all 59 interventions were explicitly described as “BCTs,” despite 9 interventions being published following the dissemination of the first BCT taxonomy in 2008. Thus researchers need to be encouraged to use the Michie et al. (2011) CALO-RE taxonomy when designing interventions and share evidence relating to behavior change, regardless of the specific behaviors or the intervention domain. Finally, it should be noted that despite the reasonable number of interventions used in this examination (n = 59), almost all interventions were conducted using developed populations, limiting the generalizability of the results beyond these groups. The scope of this review may be widened to include more recent international cooking skills intervention studies. Furthermore, the findings of the primary studies contained (n = 59) were typically self-reported measures, and therefore the usual caution must be noted with regard to social desirability of the findings.

Conclusion

By identifying and highlighting these BCTs and critiquing intervention designs, this paper offers a robust and standardized cooking and food skills intervention design template for future...
Studies in this area. These findings should facilitate the replication and adoption of effective BCTs into future cooking and food skills interventions to maximize intervention efficacy, with positive impacts on diet quality.

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