Outlook

A Quarterly Newsletter of the Society of Behavioral Medicine

Summer 2001

President's Message

Michael G. Goldstein, MD, President
Bayer Institute for Health Care Communication
West Haven, CT

Building Partnerships to Promote Adherence …and More

In my last column I announced that the theme for SBM's Annual Meeting in Washington, DC in 2002 is "Beyond Adherence: Promoting Partnerships Among Individuals, Clinicians and Systems". As I write this, our Program Chair, Susan Czjakowski, PhD, of NHLBI, and our Associate Program Chair, Karina Davidson, PhD, of Mount Sinai Medical Center, are working diligently with our Program Committee and Jane Shepard of SBM's National Office to identify Keynote Speakers, Master Lecturers and other featured elements of the program. Susan and Karina, working as true partners, have put together a wonderful committee that is sure to create a fabulous program. On the Committee's first conference call, I thanked them in advance for all the hard work that they are sure to put in. For some reason, they all laughed! I would like to take this opportunity to introduce you to the hardworking and dedicated members of our Program Committee. I hope you will contact them and let them know about your ideas and hopes for the meeting.

The Track Chairs, who are responsible for generating program elements and reviewing abstracts within a specific topic area, are listed at right. Please contact them if you have ideas for seminars, symposia, or other special events, especially if they relate to the theme of adherence. The Call for Peperswill be available on the SBM website in August.

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President's Message (con't from page 1)

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Marc D. Schwartz, PhD, of Georgetown University Medical Center, is Chair of the Local Arrangements Subcommittee. If you have ideas for local arrangements or hail from the DC area and want to help, please contact Marc Schwartz at schwartm@gunet.georgetown.edu. Other members of the Committee are: Jared B. Jobe, PhD, of NHLBI, who will coordinate the review of Rapid Communication Poster Abstracts (e-mail: jobej@nhlbi.nih.gov); Richard Seidel, PhD, Roanoke Memorial Hospital (e-mail: rseidel@carilion.com); and Evelyn Lewis, MD, MA, Uniformed Services University (e-mail: tsbrocco@usuhs.mil). Richard and Evelyn will co-lead a Subcommittee that will promote increased involvement of primary care practitioners at the Annual Meeting. Evelyn will also assist the Program Committee to insure that diversity issues are well represented on the Program. What a great team!

So, why did Susan, Karina, and I choose the theme "Beyond Adherence" for the Annual Meeting and what do partnerships have to do with adherence? To address these questions, I think it would help if you knew a little bit more about me and the paths I have taken during my career, especially the roads I have traveled as I took my first few steps. As you will see, I took Yogi Berra's sage advice, "When you come to a fork in the road, take it!"

Those of you who know me well are aware of my passion for teaching and for developing and testing educational interventions that promote patient-centered care. This passion was cultivated and nurtured during my years as a resident in medicine and psychiatry and as a fellow in Behavioral and Psychosocial Medicine at the University of Rochester. Training at the U of R was deeply steeped in the

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DEADLINE AND RATES

To advertise in the Fall issue of *Outlook*, please supply ad copy to Carol Kendall at the SBM National Office. Copy may be faxed to 608-831-5485 or emailed to ckendall@tmahq.com. The deadline for receipt of copy for inclusion in the Fall issue is September 15.

Advertising is billed at a rate of $10/line, based on *Outlook's* final layout. Sample layout and preliminary bill will be forwarded to the advertiser prior to publication.

Correspondence about articles and professional news should be sent to:

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Articles should be no longer than approximately 500 words, plus up to 10 references, and submitted to the Editor. Double-spaced papers should be submitted in a standard writing style, such as AMA or APA style. Professional news is welcome at anytime via mail, phone, fax, or e-mail.

biopsychosocial model. George Engel, the U of R's visionary medical educator and psychosomatic researcher and the person who first coined the term biopsychosocial, was an important role model and mentor. George was an internist (and yes, a psychoanalyst—but please don't hold this against him…after all, he, too was a product of his times) who modeled an approach to care that put the **patient's** perceptions, beliefs, experiences, expectations, and feelings at the center of the clinician's attention. George taught me that I had to know the patient, and hear his or her story, before I could hope to understand the patient's disease and illness. Moreover, developing a shared understanding of the problem is a prerequisite to collaborating with the patient to develop a mutually agreed-upon plan. Does this sound like building partnerships yet? Moira Stewart and colleagues at the University of Western Ontario have expanded on these principles and were among the first groups to use the term "patient-centered" care (See Stewart, M., Brown, J., Weston, W., McWhinney, I., McWilliam, C., & Freeman, T. (1995). *Patient-Centered Medicine: Transforming the Clinical Method*. Thousand Oaks: Sage).

During my fellowship in Rochester, Bob Ader (of psychoneuroimmunology fame) and Jeff Levenkron (my first model of a behavioral medicine practitioner), first introduced me to the contributions of behavior therapy, social learning theory, and the emerging interdisciplinary field of behavioral medicine. I learned how to deepen and extend the biopsychosocial model to include a more thorough assessment of the behavioral and environmental factors that influenced a patient's experience with health and illness.

Since leaving Rochester and landing first at Brown and then at the Bayer Institute, I have devoted an important chunk of my career to teaching patient-centered interviewing and counseling skills to medical students and residents and later, to practicing clinicians of all disciplines. At first, I taught these skills simply because I believed they were essential to good care. However, in my first academic position at the Miriam Hospital, my colleagues in behavioral medicine (David Abrams, Ray Niaura, Mike Follick, David Ahearn, and others) challenged me to empirically test my beliefs about the value of patient-centered approaches. For almost 15 years, I have relied on my partnerships with behavioral medicine researchers to pose and answer research questions that address this issue.

So, what do we know about the relationship between clinicians' use of patient-centered skills and health outcomes? What is the evidence that building partnerships with patients will promote adherence? In the early 1980's, Judy Ockene and colleagues at the University of Massachusetts Medical School were funded by NCI to test the efficacy of a physician-delivered patient-centered counseling intervention on patients' smoking cessation outcomes. As many of you know, Judy and her colleagues found that patient-centered counseling outperformed a usual care condition. Since then, Judy's group has also demonstrated the efficacy of a clinician-delivered patient-centered counseling intervention on dietary and alcohol-related outcomes. [1-3] Importantly, these counseling interventions were not efficacious unless system-based elements (e.g., algorithms, prompts) were also part of the intervention. Miller and Rollnick's Motivational Interviewing (MI) intervention, [4] which has shown so much promise in promoting adherence to addictions treatment as well as adherence to other targets of health behavior change, is largely based on a patient-centered model. Moira Stewart and colleagues have recently demonstrated that patient perceptions about the delivery of patient-centered care are related to a variety of health outcomes, [5] while Dana Safran and colleagues at Tufts have shown that patient adherence is enhanced when the patients perceive that their physician knows them as a person and when patients express high levels of trust in their physician. [6] Sheldon Greenfield and Sherrie Kaplan, also at Tufts, have demonstrated that an intervention that activates and empowers patients to take a more active role in their care enhances outcomes of chronic disease, [7, 8] while Williams and colleagues at the U of R have found that patients' motivation to self-regulate glucose levels was increased and glucose control was improved when clinicians supported patients' autonomy and welcomed active patient participation in treatment decisions. [7, 8] Our own research has demonstrated that a patient-centered approach to delivering physical activity counseling is associated with short-term, though not

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Mark your Calendar...

The 2002 Annual Meeting and Scientific Sessions will be held April 3-6 at the Omni Shoreham Hotel in Washington, D.C.

The theme for the meeting is "Beyond Adherence: Building Partnerships Among Individuals, Clinicians and Systems". Please plan to join your behavioral medicine colleagues next Spring in Washington, D.C. for this important meeting!

Depression and Suicide in General Health Care Patients

Steven Richards, PhD, Dept. of Psychology, Texas Tech University
Michael G. Perri, PhD, Dept. of Clinical and Health Psychology, University of Florida

It is not uncommon for patients in general health care settings to evidence both depression and suicidal risk (1). All practitioners in behavioral medicine will see patients with these signs and symptoms. Therefore, we thought that it would be useful to provide a brief overview of the empirically established risk factors for suicide, along with a few comments on assessment, treatment, and sample studies in health care and community settings. This short article relies, in part, on a book that we are just completing, which is titled *A Primer on Depression* (1).

There are numerous recent reviews of the empirically established risk factors for suicide in adults (1-6). The well-established *clinical risk factors* are the following: Depression, substance abuse, panic disorder, schizophrenia, previous suicidal attempts or a history of suicidal ideation, hopelessness, severe inability to experience pleasure, and chronic sleep disruption. The well-established *demographic risk factors* are the following: male, white or Native American race, living alone, widowed or divorced, recent negative event such as trauma or severe loss, unemployed or experiencing serious financial problems, and the combination of being over 69 years of age and male.

Hirschfeld and Russell (2) suggest a simple assessment outline for part of the first interview with a potentially suicidal patient: (a) assess demographic risk factors; (b) ask about stress; (c) evaluate depression and anxiety; (d) screen for substance abuse; (e) assess suicidal ideation and plans, plus previous suicidal attempts and family history of suicide; and (f) evaluate the overall suicidal risk, including a summation of the risk factors. Always arrange for immediate and intensive care if the risk appears high.

The professional consensus favors treatment plans for suicidal patients that are immediate, intensive, and comprehensive (1-3, 5-12). The immediate aspect may require initiating treatment during the initial assessment. The intensive aspect may require brief hospitalization (day and night) and frequent psychotherapy. The comprehensive aspect may require long-term pharmacotherapy–and perhaps ECT–in cases that do not respond to the more standard treatment package of brief hospitalization (day and night), plus moderate-length psychotherapy and pharmacotherapy. We have argued elsewhere that an *empirically* supported version of a brief psychotherapy for depression–such as cognitive behavior therapy or interpersonal psychotherapy–should always be included in the treatment package for depressed and suicidal patients (1, 11-12; cf. 18). This treatment recommendation applies to suicidal patients who are seen in general health care settings (1, 11-12; cf. 3, 5, 7-9, 18).

There are numerous treatment guidelines and "what-to-do" lists on this issue, that go far beyond the scope of this brief article (1-2, 5-12) . Five frequently mentioned guidelines, however, are the following: (a) stay calm, be prepared to take action and protect yourself; (b) communicate empathy and that you really do care; (c) get expert consultation; d) the *Legal Standard of Care* is typically defined as care that is "average, reasonable, and prudent"; and (e) a limit to confidentiality may occur in a case where the patient presents a clear and immediate danger to himself or herself.

Some excellent research has been done in this area, including numerous recent studies. For example, Cooper-Patrick and her colleagues have developed a promising four-item screening questionnaire for assessing suicidal risk in general medical patients (13). Brown and his colleagues report on a 20-year longitudinal investigation that further supported the risk factors of depression, suicidal ideation, hopelessness, and unemployment (14). Henriksson and his colleagues found that 93% of the suicide victims in their sample had symptoms justifying a psychiatric diagnosis, including 59% with symptoms suggesting major depressive disorder or dysthymic disorder (15). Kessler and his colleagues have reported an epidemiological survey that suggested concrete suicidal plans generate three times more risk than abstract suicidal thinking (16). As a final example, Rotheram-Borus and her colleagues found that a brief emergency room intervention for enhancing adherence to outpatient psychotherapy evidenced positive effects for female adolescents who had attempted suicide, particularly for patients with the most severe psychiatric symptoms (17).

For readers who would like to pursue detailed literature reviews of this area, we recommend the *Practice Guidelines* developed by the American Psychiatric Association (7:cf.18), and the books by Bongar et al. (8), Jacobs (3), Maris et al. (5), and Roberts (9). These scholarly reviews are excellent resources.

All practitioners in the area of behavioral medicine will see depressed and suicidal patients. The question is not *if*, but *when.*

continued on next page

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President's Message (continued from page 3)

long-term, changes in motivational readiness to engage in regular physical activity. [9] So, converging evidence suggests that building partnerships with patients is an effective strategy for promoting patient adherence and behavior change. Hence, the inclusion of "building partnerships" in the Program theme! As I argued in my previous column, the term adherence does not quite capture the essence of a truly collaborative relationship. That's why we framed the theme as "beyond adherence".

In the next column, I will try to articulate the ways in which collaborative partnerships between clinicians and agents of health care systems can promote clinician adherence as well as system evolution and change. In the meantime, I hope you all will consider submitting papers, posters, symposia, and seminars that address the program theme. Please contact Program Committee members with your ideas and be on the lookout for the 2002 SBM Annual Meeting Call for Papers. Perhaps you will consider building a partnership with a colleague to collaborate on an abstract submission!

Best wishes for the rest of the summer.

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Editor Search

The SBM Board of Directors will be searching for a new Editor for *Outlook* during the upcoming academic year. The new Editor will take office during the Summer of 2002. SBM members who are interested in the editorial position should send a short cover letter and a vita to Ms. Beth Klipping, Executive Director of SBM, at the SBM National Office (contact information can be found on page 1 of this issue of *Outlook*). In addition to the standard editorial tasks entailed by a newsletter of a professional society, the Editor of Outlook recruits news items and short discussion articles that will interest the SBM membership. Four newsletters are published each year, with publications deadlines of approximately September 15, December 15, April 1 (following the Annual Meeting), and June 15. The staff members at the SBM National Office handle newsletter formatting, production, classified ads, and so forth. The present Editor of Outlook is on record as repeatedly stating that the national SBM staff members are great to work with! If SBM members who are interested in this editorial position have questions for the present Editor, they are welcome to contact him (steven.richards@ttu.edu; 806-742-3711 ext. 254). Interested parties should send a short cover letter and a vita to Ms. Klipping on or around September 15, 2001.

Cancer Special Interest Group (SIG) Now Forming!

For those SBM members interested in cancer related behavioral science, please consider joining the new Cancer SIG. This SIG was initiated at the recent SBM Annual Conference in Seattle and the sign-up response was very encouraging. If you are interested and have not signed up, please contact Dr. Michael Stefanek at ms496r@nih.gov. We are still in the process of planning and organizing the SIG, so this is your chance to get in on the ground floor. We are interested in your participation if you are interested in any aspect of cancer control, including prevention, early detection, treatment, and survivorship issues. When you contact Dr. Stefanek at the address noted above, please indicate: 1) your specific area of interest within cancer control; 2) your thoughts on the mission of the SIG; 3) whether you might be willing to be contacted to help as the SIG develops and maintains its mission; and 4) your name, office address, phone, and email.

Call for Papers

Beyond Adherence: Building Partnerships Among Individuals, Clinicians and Systems

2002 Society of Behavioral Medicine Annual Meeting
Call for Papers Deadline Date: Friday, September 14, 2001

Individuals are invited to submit their research for presentation at the 2002 SBM Annual Meeting through the Call for Papers. Submissions from multidisciplinary and ethnically diverse groups are strongly encouraged. All proposals must be submitted electronically no later than 12:00 midnight (CST) on Friday, September 14, 2001. Please review the submission instructions available on the SBM website (http://www.sbmweb.org) carefully. All abstracts must be submitted on-line through the SBM website. Submission of a proposal implies a commitment to present at the meeting, and all participants are expected to register. Notification of acceptance or rejection of abstracts will be e-mailed to the designated corresponding author no later than January 1.

Presentation Descriptions

Each of the following are presentation formats at the SBM Annual Meeting.

Papers which cluster around common themes will be selected for group oral presentations of approximately 15 minutes.

All papers submitted under the "Paper or Poster" option that are not selected for oral presentation will be considered for poster presentations.

Poster Presentations allow presenters to discuss their research with interested colleagues over a period of 90 to 120 minutes in an informal setting.

Symposia examine important issues from a variety of perspectives, through supporting data. Over a period of 90-120 minutes, alternative solutions, interpretations, or points of view on a body of knowledge are presented and debated. Consideration of diverse discipline and ethnicity implications are particularly welcome.

Seminars are three hour pre or post meeting presentations by 1-3 speakers which emphasize the theory and application of practical skills.

Topics

Each corresponding author will be asked to select one of the following topics in which their abstract submission will be reviewed.

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CLASSIFIEDS

Valley Mountain Regional Center
Stockton, California
Clinical Psychologist

Valley Mountain Regional Center is one of California's 21 nationally recognized centers for comprehensive services to developmentally disabled children and adults. VMRC has an opening for a Clinical Psychologist to provide a broad spectrum of clinical services including but not limited to intake and eligibility, coordination of mental health services for consumers, consultation to case management, clinical and community services departments, diagnostic and forensic assessments, psychological interventions, and staff, consumer and provider training. Position requires a Doctorate in Psychology or Educational Psychology from an accredited university. Two years of clinical experience, preferably one year in the field of developmental disability. Possession of psychologist license issued by the California State Board of Psychology or currently eligible for licensure by the California State Board of Psychology. We offer our employees excellent benefits, including CalPERS retirement and health insurance; Dental coverage for employee and family; Vision care plan for employee and family; Life & Accidental Death and Dismemberment Insurance, Long-Term Disability Insurance, Generous vacation, sick leave, bereavement leave and compensatory time off plus 15 _ paid holidays; Flexible work schedules; IRS 125 Cafeteria Plan; and Employee Assistance Plan. Salary commensurate with experience. To apply, download the application forms from the website (www.vmrc.net) and mail along with a cover letter and resume to Tina Reed, P.O. Box 692290, Stockton, CA 95269 or fax to (209) 955-3249. You may also request an application by calling (209) 955-3621.

Social & Behavioral Sciences
Cancer Research Center of Hawaii
University of Hawaii (Honolulu)
Faculty Positions

The Cancer Research Center of Hawaii, University of Hawaii, is seeking two outstanding behavioral scientists for faculty positions. Cancer Research Center of Hawaii (CRCH) is a university-based, Natl. Cancer Institute-designated cancer center. CRCH offers a unique opportunity to study & influence Hawaii's diverse multiethnic populations, with disparate rates of cancer morbidity and mortality.

The appointee will work 50% time assuming a leadership role in currently funded research projects in one or more of these areas: smoking prevention, skin cancer prevention, colon cancer detection, dietary change, & underage drinking prevention. 50% time will be spent on developing original funded research. S/he will be expected to develop original externally funded research within 2-3 years.

Qualifications for Asst. Researcher (Professor) appointment: doctoral degree in health behavior, psychology, or related field. Other requirements: strong research & community relations experience; thorough knowledge of health behavior & intervention research; leadership/supervisory experience and skills. Experience in cancer prevention/ control, and with ethnic minorities, is also desirable.

To apply, send a cover letter summarizing your qualifications, experience and interests, a current CV, and 3 references to: Karen Glanz, PhD, MPH, Cancer Research Center of Hawaii, 1236 Lauhala St., Suite 406, Honolulu, HI 96813 Closing date: July 28, 2001 or when position is filled. University of Hawaii is an Equal Employment Opportunity/Affirmative Action Employer. Inquiries: Karen Glanz, Ph.D., M.P.H., (808) 586-3076; fax (808) 586-3077; e-mail kglanz@hawaii.edu

Memorial Sloan-Kettering
Cancer Center
Department of Psychiatry and
Behavioral Sciences
New York, New York
Faculty Position

We are seeking a behavioral scientist (PhD, DrPH, MD/MPH) to join our Prevention, Control and Population Research Program, an active multidisciplinary research group of over 20 investigators with interests in classic and molecular epidemiology, genetic testing, cancer risk reduction, screening and early detection, chemoprevention, health outcomes and cancer survivorship. Translational research collaborations within the institution, particularly the Clinical Genetics Service, Cancer Prevention and Wellness Center, and ties to community populations are well established. Potential collaborative research initiatives with the Clinical Genetics Service include behavioral outcomes after testing (e.g., screening behavior), tailored genetic counseling and risk communication, and studies of family dynamics (e.g., disclosure, decision making) during the testing and counseling process.

Primary faculty appointment would be within the Department of Psychiatry and Behavioral Sciences which was established in 1977 and currently has 10 full-time faculty. Faculty hold academic appointments through the Weill Medical College of Cornell University. Faculty currently conduct research in: 1) tobacco cessation; 2) colorectal, oral and lung cancer screening; 3) interventions to promote psychosocial adaptation among cancer patients and family caregivers; and 4) assessment of quality of life outcomes. There is a strong commitment to addressing disparities in cancer control and many current research projects target urban, medically underserved populations. Experience/interest in either behavioral aspects of genetic testing, cancer risk communication, early detection/cancer screening and/or cancer behavioral risk reduction/health promotion in youth highly desired. Successful track record of peer reviewed funding and publications preferred. Junior faculty candidates with strong potential to develop and maintain an independent research program are also encouraged to apply. Academic rank and salary will be commensurate with credentials of the successful applicant. Successful candidates will be expected to design and implement innovative programs of research in cancer prevention and control and mentor pre- and postdoctoral research trainees supported by federal training grants. Opportunities for integrating clinical activities complementary to research interests are available and encouraged.

Send cover letter summarizing research interests/experiences, curriculum vitae and at least three references to: Jamie Ostroff, Ph.D., Chair, Search Committee, Department of Psychiatry & Behavioral Sciences, Memorial Sloan-Kettering Cancer Center (MSKCC), 1275 York Avenue, New York, NY 10021 or fax. (212) 230-1953 or email ostroffj@mskcc.org. MSKCC is an EO/AA Employer.

Dr. Matilda White Riley Lecture Series
Soaring: An Exploration of Science and the Life Course

The Office of Behavioral and Social Sciences Research, National Institutes of Health (NIH), in collaboration with four NIH Institutes, is presenting five lectures to recognize and honor the contributions of Dr. Matilda White Riley. Dr. Paul B. Baltes, Director of the Max Planck Institute for Human Development (Berlin, Germany) will deliver the inaugural lecture of the series. His lecture on *Biocultural Dynamics of the Life Course: A Difficult Journey from the Third to Fourth Age?* will be held on September 14, 2001 at 3:00 PM in the Natcher Building (45), Room F1-F2, on the NIH campus in Bethesda, Maryland. The National Institute on Aging (NIA) is hosting a reception immediately following the lecture.

The lecture topics reflect the main substantive areas of Dr. Riley's contributions over her career: fertility behaviors, mass communications, health and behavior, life course perspective, and age and aging. Information about Dr. Riley and the lecture series is posted at http://obssr.od.nih.gov/soaring/.

The title of the lecture series is drawn from Dr. Riley's early interest in the sport of soaring and gliding and is a metaphor for her professional and private life. Creativity, vision, and adventure have hallmarked both.

Other NIH sponsors of the lecture series are the National Institute of Child Health and Human Development; National Cancer Institute; and National Heart, Lung and Blood Institute.

Lecture Series Topics: For additional information, please contact Dr. Ronald P. Abeles at (301) 496-7859.

Biocultural Dynamics of the Life Course: A Difficult Journey from the Third to Fourth Age?
Paul B. Baltes, PhD

Teenage Childbearing across the Generations: Reality or Myth
Frank F. Furstenburg, Jr., PhD

Health Campaigns in the Age of Ubiquitous Media: Promise and Peril
John R. Finnegan, PhD

Gender Differences in Heart Disease: Let Me Count the Ways
Karen Matthews, PhD

Successful Aging: Prescriptions and Persisting Problems
Robert L. Kahn, PhD

Call for Papers (con't from page 6)

- Addictive Behaviors/Alcohol/Tobacco/Substance Abuse
- Arthritis and Chronic Pain
- Cancer
- Cardiovascular Disease/Blood Pressure/Reactivity
- Chronic Disease Management/Adherence
- Lifespan Development Issues
- Population Health/Health Policy
- Prevention of Risk Behaviors
- Psychoneuroimmunology and AIDS
- Psychosocial Influences on Disease
- Translation/Research to Practice

Submission information is available by visiting the SBM website at http:www.sbmweb.org and clicking under the Annual Meeting.

Rapid Communications Posters: To offer a forum for the very latest findings in behavioral medicine, the Program Committee will review submissions for posters only. All Rapid Communications posters must be electronically submitted and received by 12:00 midnight (CST) on Friday, January 11, 2002. Submission information for Rapid Communication Posters will be available on the SBM website in November.

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