



Outlook

A Quarterly Newsletter of the Society of Behavioral Medicine

Summer 2002

President's Message

David B. Abrams, Ph.D., SBM President

Centers for Behavioral and Preventive Medicine, The Miriam Hospital, Providence, RI



Spring is a time of new growth, energy, renewal, and rebirth. At the heart of SBM's renewal and future are questions that we must ask ourselves. Now that SBM is almost 25 years old, has come of age, and achieved its original goals, what remains unique and special about SBM that is difficult to obtain elsewhere, such as in smaller and more focused "designer" organizations, larger professional societies,

or in organizations representing one's primary discipline? What does SBM's biopsychosocial approach to understanding health and illness offer the scientific community and society, now that almost everyone has embraced the idea of transdisciplinary research to address complex health-related problems? Why has the wealth of evidence-based knowledge from the translation of science into practice, accumulated under the SBM umbrella, not been fully deployed to inform individual, family, community, health care delivery, and ultimately, population health enhancement? Where is SBM now in a world that has changed dramatically, and where should we be going in the next decade? What activities and areas do you, our members, want your Society to focus on? Where can we make the biggest impact and leverage our approaches to research and practice for the greatest value and return on the investment with which society has entrusted us?

SBM is special. SBM fills a unique place in my professional space—space that societies representing my primary discipline and my more focussed interests do not. I need an umbrella society like SBM. Where else can you hear about fundamental science across multiple risk factors, diseases and levels from cells to society? Where do you get a biomedical, psychosocial and population health perspective? Where can you find debates about translating research to practice across the disease continuum from primary prevention to screening, treatment, rehabilitation and end of life issues? Where can nurses, physicians of various specialties, psychologists of many orientations, social workers, biomedical scientists, educators, population, public health and other professionals share their different perspectives, find common ground, and learn from one another? SBM is a community of supportive and diverse groups. SBM can and does offer something unique and value-added.

As Kahn and Prager (1994) recommend in their description of the process of transdisciplinary research to practice—the notion of being a transdisciplinary thinker, researcher, or practitioner must be central to what you do as a professional, not something done "on the side" as an "add on" to your primary field or discipline. One needs to constantly counteract the "centripetal" forces pulling one away from SBM and back towards one's own discipline, department, or subspecialty

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SBM National Office

7600 Terrace Avenue, Suite 203 • Middleton, WI 53562

TEL: 608-827-7267 • FAX: 608-831-5485

EM: info@sbmweb.org • Web: <http://www.sbmweb.org>

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"silo". As we learn more about the complexity of human behavior from gene-environment interaction to the importance of the larger socioeconomic environment and other contextual factors in driving the health behavior of populations, we see that transdisciplinary team approaches are increasingly being adopted. SBM led the way, but now many scientists, practitioners, and policy-makers are seeing the value of using transdisciplinary processes in moving the field forward in the 21st century.

Transdisciplinary research and its translation into practice is about listening across the gulf that separates disciplines and professions, developing a common language and a new synthesis of measures and methods, and addressing complex problems in new ways. SBM is one of those unique places where you can learn the common language, develop new theoretical models, measures, methods, and examine how to translate science into service delivery and policy. Indeed the theme of next year's meeting—transdisciplinary, translational, transcultural and transnational—captures the ambitious depth and breadth of vision made possible by the core values of SBM. These values have stood the test of time. There is much work still to be done if we are to bring science and practice to bear on making a measurable impact on improving population health and well being in an efficient and effective manner. The SBM vision remains vital, vibrant, and more valuable today than 25 years ago. I feel lucky to be a part of SBM, able to continue my own professional growth and development because of the grounding in rigorous evidence-based science and the ability to embrace and learn about the incredible ways that other disciplines and views can enrich my own professional life.

Deadlines 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 emailed to Carol at ckendall@reesgroupinc.com or faxed to 608-831-5485. The deadline for receipt of copy for inclusion in the Fall issue is September 6.

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

As we implement our strategic planning group's recommendations and explore the ways we can reinvigorate, reinvent, and refocus our Society on the challenges of the 21st century, here are some more details about five of the areas we are addressing that I touched on in my last column. The Board is eager for you to get involved. Let us know what you like and do not like about the directions we are recommending. Are we missing something critical? Is there a place where you may want to get more involved in helping us make it happen (e.g. join a SIG, start a new SIG, or a new working group, committee or council)?

1. Do we need a name change or an expansion/clarification of who we are and what we have to offer? It has been suggested that we add the word "Health" to our name—The Society of Health and Behavior or Health and Behavioral Medicine. Another idea is to keep the name we know and love, but add a byline such as Society of Behavioral Medicine: a health and behavior organization. Let us know what you think.
2. Advocacy/Marketing Task Force, David Abrams, Chair. SBM needs a stronger voice where the action is—on the Hill in Washington, DC, in key coalitions where health, health care delivery and health policy are forged. Some objectives include developing a capacity for advocacy; providing expert testimony in senatorial and congressional appropriations committees, at the NIH and with key service delivery constituencies; hiring a lobbyist or policy advisor; and building bridges with like-minded groups and

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Please send *Outlook* correspondence to:

Cheryl L. Albright, Ph.D., M.P.H.
Editor of *Outlook*

Stanford Center for Research in Disease Prevention
1000 Welch Road, Palo Alto, CA 94304-1825
Tel: (650) 725-0737 • Fax: (650) 725-6906
Email: cheryl.albright@stanford.edu

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 using APA or AMA writing style. Professional news is welcome at any-time via mail, phone, fax, or e-mail.

Outlook on Life

Cheryl Albright, Ph.D., M.P.H.
Stanford Center for Research in Disease Prevention, Palo Alto, CA

I will be taking over the role of the Editor of *Outlook* for the next 3 years, starting with this issue. Steven Richards has done a great job, so it will be hard to follow in his footsteps. I am sure I can speak for all SBM members in thanking him for all his hard work and dedication to SBM. I am very excited about taking on this new role, and I am looking forward to working with the SBM Board to make *Outlook* a resource that is informative, provocative, unifies members, and is engaging.

First, let me tell you a bit about myself. I am a Senior Research Scientist at the Stanford Center for Research in Disease Prevention, at the Stanford University Medical School. My work has focused on behavioral interventions to reduce

cardiovascular risk (e.g., nutrition and physical activity) and health education interventions to encourage repeat mammography. I have conducted studies with primary care physicians (e.g., the Activity Counseling Trial) as well as community-based studies to increase physical activity in low-income, multiethnic women (e.g., the IMPACT Project—Increasing Motivation for Physical ACTivity). I have been an active SBM member for 20 years and have presented my research at many SBM annual meetings. I review manuscripts for 10 journals and serve on NIH grant review committees.

So that's my academic background in a nutshell. Besides this "standard" way of describing myself, I thought there could be a new way for members to learn about me and each other.

So, a new item I am including in *Outlook* is a column that "surveys" behavioral researchers in a new way. Basically they will reply to questions similar to the ones James Lipton asks guests on the TV show "Inside the Actor's Studio". I love this show. If you are not familiar with it, the host interviews actors about the movies/plays they have done and asks them to reflect on the "craft" of theater and film. At the end of the show he asks them a set of questions developed by Bernard Pivot. (See <<http://www.bravotv.com/series/actorsstudio/frames/index_ad.html>> for guests' responses to these questions.) I will be asking SBM members to reply to 10 questions, so we can get a small "picture" of their personality and maybe even a small inkling of their "outlook on life" (which is the title of the new column). I hope the column will also be an "outlet" for people's creativity and perhaps their sense of humor. I have slightly adapted the questions to make them a bit more relevant to our field and this "venue". So, to kick off the new column I will be the first one to answer the survey. (See box at left.)

<i>Outlook On Life</i>	Cheryl Albright, Ph.D.
What is your favorite word?	Healthy
What is your least favorite word?	Rejected
What "turns you on" or excites you about the field of behavioral medicine?	Dealing with behaviors that can prevent disease and improve quality of life. Also, working in a field that involves many different types of professionals (PhDs, MDs, RNs, MPHs, etc.).
What turns you off /frustrates you about the field of behavioral medicine?	The lack of federal funds for behavioral medicine research and a lack of respect for the field.
What sound or noise do you love?	My daughter singing
What sound or noise do you hate?	A barking dog
What was the most unusual job (outside of behavioral medicine/academia) you ever had?	Making and selling garlic fries at a "food court" in a large amusement park.
What profession, other than yours, would you like to attempt?	Nature photographer
What profession or job would you not like to participate in?	Selling garlic fries and any job in a Tobacco Company.
If Heaven exists, what would you like St. Peter to say when you arrive at the pearly gates?	Go back they still need you.

Spotlight on Education and Training

Editor's Note: This is a new column for *Outlook*. Its purpose is to highlight pre-doctoral, internship, and post-doctoral training programs in behavioral medicine. Although the SBM Directory of Training Opportunities (available on the SBM website: <<http://www.sbmweb.org>>) provides a quick way to search programs by state, specialization, or type of training, I hope this column will provide some useful "insights" about these programs, including the perspective of a current student/trainee. The detailed information listed about the programs in the Directory will not be repeated here, but, instead, the uniqueness and "richness" of these programs will be illustrated. One training program per issue will be asked to answer six questions about the program and three questions for a current student/post-doc.

To kick off the first column, the Cardiovascular Disease Prevention Post-Doctoral Training Program at the Stanford Center for Research in Disease Prevention (SCRDP) in Palo Alto, California will be featured (due to convenience and partiality, since I am located at this Center!).

Interviewed: Stephen P. Fortmann, M.D., Program Director
Abby C. King, Ph.D, Associate Director
Stanford Center for Research in Disease Prevention (SCRDP)
Date: June 2002

1. What types of research programs do your post-doctoral fellows typically become involved in?

A broad spectrum of behavioral medicine research is conducted at SCRDP, including basic science, epidemiological, and clinical research. We conduct behavior change research on physical activity/fitness, smoking cessation, nutrition, weight control, as well as adherence to medical regimens. The study samples are multiethnic and range in age from children/adolescents through adulthood, including older adults/seniors. Post-docs can link up with existing community-based studies and randomized clinical trials, or work with faculty to analyze data from completed studies.



Stanford Campus

2. What kinds of support (other than stipends) do you provide fellows? (i.e., access to computers/statistical programs, travel funds, etc.)?

Fellows are provided access to computers and statistical programs such as SAS. Funds are also provided for travel to professional conferences.

3. Does your program have any required academic coursework or clinical responsibilities?

Fellows attend weekly one-hour research seminars, and attend seminars on ethical issues related to research. They are also invited to attend seminars focused on statistical issues in medical/public health research. Fellows with a degree in clinical psychology can undertake hours in this applied research setting that in most cases fulfills some requirements towards clinical psychology licensure. Otherwise, there is no required coursework. Physicians may participate in a weekly, half-day Preventive Cardiology Clinic and other appropriate clinical activity up to a total of 8 hours per week.

4. What do you think makes your program unique within Behavioral Medicine?

Its multidisciplinary faculty and the wide range of research projects that provide fellows with practical "hands-on" experience in implementing research studies (e.g., recruitment/retention of subjects, intervention methods, survey design, etc.), and an understanding of the theoretical foundation upon which research studies are built. Also, we encourage fellows to develop a postdoctoral experience that meets their personal and professional needs and preferences. Post-docs can choose one faculty and his or her research projects within the Center or choose several different faculty/programs to work with over the two-year fellowship.

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5. How do you think your program will change in the future (next 5 years)?

Collaboration with Stanford faculty outside the SCRDP has been increasing, allowing us to develop interesting bio-behavioral studies including research on gene-environment interactions. We will continue to develop our capabilities in the area of technology applications in the public health arena, as well as continuing to broaden our reach into underserved segments of the population (e.g., frail elderly, low-income families; non-English speaking populations).

6. What one “tip” or piece of advice would you give to prospective applicants?

Visit our website : <<<http://prevention.stanford.edu/>>> to become familiar with the research we are doing and to identify one or two faculty with whom you think you would like to work. The web site contains information on current research as well as more detailed information about the Fellowship program, including application materials. Inquiries can be sent to Dinah Hazell at << dhazell@stanford.edu>>.

Current post-doc's or student's perspective:

Interviewed: Audie Atienza, Ph.D.
Post-doctoral fellow SCRDP
Completed three-year fellowship in June 2002

1. What is the most important thing you have learned as part of your post-doc fellowship?

Through my post-doctoral experience at SCRDP, I have gained an appreciation for the importance of interdisciplinary work in the pursuit of chronic disease prevention research. The public health, epidemiological, and community-based health perspectives have complemented my background and training in behavioral medicine. In short, the post-doc has helped me conceptualize health and disease from a number of different perspectives.

2. How has the program impacted your career development?

The post-doc at SCRDP has been instrumental in my career development. I recently accepted a position as a Health Research Specialist at the National Cancer Institute, Behavioral Research Program, Health Promotion Research Branch. The

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Spotlight on SIGs—Special Interest Groups

Lisa A.P. Johnsen, Ph.D.
Center for Ethnic Minority Health Research
Northwestern University Medical School, Chicago, IL

Editor's Note: This is a new column for OUTLOOK. Each issue will feature a description of one of SBM's Special Interest Groups. These groups typically meet during the annual SBM scientific sessions, but they can also have a range of ongoing activities. This column will allow the SIG to inform SBM members about their goals and activities. Information about who to contact will also be provided for those who might like to join the SIG. The first SIG column describes one of the newest and fastest growing special interest groups is the Ethnic Minority and Multicultural Health (EMMH) SIG, which is chaired by Lisa Johnsen, Ph.D., (Northwestern University Medical School) and co-chaired by Jasjit S. Ahluwalia, M.D., M.P.H., M.S. (University of Kansas), and Julian Thayer, Ph.D. (National Institute on Aging).

The EMMH SIG concerns itself with advancing the field of ethnic minority and multicultural health, through education and training, networking, mentorship of ethnic minorities and non-minorities, and conducting research in ethnicity, culture, and health. Members of this SIG also aim to increase the involvement of ethnic minorities in the SBM council, SBM committees, and the peer-review process.

Approximately 40 people attended the first annual meeting of the EMMH SIG in April, 2002. Since the first meeting, the EMMH SIG has developed a list-serv and membership has increased to approximately 160 members. The EMMH SIG is currently in the process of refining their mission statement and objectives for the SIG.

Members of the EMMH SIG are also looking forward to the upcoming 2003 SBM conference, as they hope to submit and sponsor many innovative abstracts that reflect one of the four conference themes: “Bridging Boundaries in Behavioral Medicine: Transdisciplinary, Translational, Transcultural, and Transnational”.

If you are interested in ethnic minority issues or ethnic minority health and would like to join the EMMH SIG, please contact Dr. Lisa Johnsen at l-johnsen@northwestern.edu. ♦

Outlook

A Student's Perspective . . .

Amy Heard-Davison, Ph.D.
University of Washington Medical Center, Seattle, Washington

Editor's Note: This is a new column for Outlook. Each column will be written by a graduate student, post-doctoral fellow, or intern who is undergoing training in Behavioral Medicine. I hope this column will give students a chance to share their views and network with each other and SBM members. The first student to volunteer to write a column is Amy Heard-Davison of the University of Washington.

As Student Committee Chair for the Membership Council, I am very excited about the new opportunities for and focus on student/trainee members of the Society of Behavioral Medicine. I'd like to begin this column by thanking Cheryl Albright, the *Outlook* editor, for acknowledging that aspect of our membership and coming up with the idea for this student-focused column. According to Dr. Albright, it will provide "a forum for students (and trainees) in Behavioral Medicine programs" and a chance for us to voice "comments on where (we) think the field should go, controversies in the field, ethics of behavioral medicine, treatment of students working in research projects, how training programs should be changed, or basically anything we want to address . . . from a student's perspective." This feature will be written by a different SBM student or trainee member for each issue, and I hope it will become an important contribution for both those in training and the membership in general.

I'd like to use this first installment to inform students and other SBM members about the services available to those in training and encourage you to seek them out and use them to the fullest. I am currently finishing up my second year of postdoctoral fellowship at the University of Washington Medical Center in reproductive and sexual medicine, and my chief regret as I look back on my own training experiences are those opportunities for learning I didn't pursue. I know it sounds like a challenge with all that you have on your plates as trainees, but at no other time in your career will these opportunities be made so available and will you be expected to be in the primary role of "learner."

The Education and Training Council, headed by Shari Waldstein, has a well-developed program that can be accessed via the website. It provides information on opportu-

nities for training in behavioral medicine for a variety of disciplines and specialties. It also offers curriculum guidance for the training programs themselves. In addition, they sponsor the expert consultation service, a popular service at the annual meeting that allows young researchers and professionals to consult with more experienced members in their field on current or future projects.

Other services available at the annual meeting include the psychology internship and postdoc preparation roundtables and the career development workshop and track. There are opportunities for financial breaks for student member volunteers who help out at the convention, and SBM offers reduced rates for members currently in training programs (through the postdoctoral level). SBM also offers one year of reduced dues to those transitioning from student to non-student membership status.

The Mentoring Committee, headed by Judy Ockene, has been working hard to develop a program that connects junior members of SBM with more senior researchers and clinicians for one year or longer. Plans are currently in development to expand this program to include graduate students, and the program has been quite successful for those who already have an advanced degree and are early in their careers.

The Membership Council, headed by Martita Lopez, is especially interested in learning more from students about which services they find helpful, use most often, and would like to see added. We also want to know what services will keep you around even when your training is finished. To facilitate this process, I will be sending out a survey within the next few months and encourage you to use this opportunity to make your voice heard.

Thanks very much to all of the members for their dedication to training. I'm hopeful that some of the best ideas for programs or ways to expand the ones we have to benefit students and trainees are yet to come—from you!

<aheard@u.washington.edu>



EBBM: Making Progress with Eyes Wide Open

Bonnie Spring, Karina Davidson, Evelyn Whitlock, and Kimberlee Trudeau for the EBBM Committee

For the past two years, the EBBM Committee has attempted to articulate and disseminate ideas about how to apply or adapt Evidence-Based Medicine (EBM) to Behavioral Medicine. This dissemination has taken many forms including *Outlook* articles such as this one, an *Annals of Behavioral Medicine* manuscript, a post-conference seminar at the SBM 2002 Meeting, and the establishment of an EBBM Special Interest Group (SIG). Although our efforts have been met with much enthusiasm, the evidence-based discussions have raised a number of issues (1-2), some of which result from the experience of medical disciplines that have generally endorsed an evidence-based approach to treatment. These issues include the challenge of applying evidence-based research standards in disciplines like pediatrics that have limited clinical research data (3), and the dearth of methods to adequately examine therapies in combination (4). Some propose that clinical judgment, rather than being relegated to the lowest level in a best-evidence hierarchy, should be construed as a different type of information that guides in the absence of empirical data (5) and complements empirically-derived evidence (6). Others note that evidence-based policies are not immune to the politics of special interests (7).

We feel strongly that: a) the concerns expressed about the EBBM movement are important to consider in open dialogue; b) that these issues can be addressed and resolved by the burgeoning EBBM movement; c) that the resulting, continuing dialogue is vital and useful and can improve the nascent discipline; and d) that EBBM will place our field in a stronger position in clinical practice and in research. The intent of this article is to continue the dialogue about unresolved issues in the foundation of the evidence-based movement. Thus, we offer a partial listing and discussion of issues that have been raised in various critiques (8-9) of the evidence-based movement. We invite you to share your thoughts and comments so that our movement can be informed and shaped by a free and full exchange of ideas. Here, in no particular order, are a few of the cautionary notes that we have encountered regarding the evidence-based movement.

Is EBBM Applicable to Clinical Practice?

- Restrictive enrollment criteria, implemented to enhance internal validity in clinical efficacy trials, can have the unintended consequence of excluding more representative clinical cases (e.g., those with co-morbidities).
- Overworked, under-supported practitioners may work in settings that actively discourage EBBM by not reimbursing behavioral intervention at all or not reimbursing the number of sessions needed to deliver many evidence-based treatments.
- Many non-behavioral interventions are reimbursed with only limited or no evidence base. The criteria for reimbursement of behavioral interventions should not differ from those for non-behavioral interventions.
- Treatment manuals are difficult to obtain; they can also be insufficiently developed to address clinician training needs, or too inflexible to respond to diversities in client characteristics and courses of recovery (10).
- Evidence-based behavioral medicine may be misapplied by policy-makers, payors and/or practitioners who misunderstand the approach and misinterpret it as prescribing a narrowly formulaic (“cookbook”) approach to healthcare.

Neglected Issues in Research on Evidence-Based Treatment

- The focus on randomized controlled trials (RCTs) to the exclusion of other designs in developing an evidence-base is detrimental because: a) many patients are unwilling to be randomized to treatments, particularly when one assignment option involves inert or ineffective treatment; and b) the RCT’s evaluation of a single sustained treatment fails to reflect usual practice, in which shifts in treatment occur until a desired outcome is achieved and maintained.
- Research documentation and reporting of critical phenomena, such as treatment delivery (fidelity), therapy process measures, and population reach are infrequent.
- Relevant outcomes including functional status, quality of life, durability of change, potential negative or iatrogenic outcomes, cost of treatment, and client satisfaction have been neglected by researchers.
- New developments in basic science research are needed to spur the development of novel treatment approaches (11). If basic research dwindles, new treatments may not receive the research attention necessary to become evidence-based and the field may stagnate.

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- A major challenge concerns the need to develop and nurture systems that support the translation of evidence-based, proven interventions into practice. Experience to date with EBM has been eye-opening and contradicts the premise that, "If you tell providers, they will change." This specific issue is sufficiently large, complex, and important that we will address it alone in our next *Outlook* article.

Possible Long-Range Adverse Implications for Science, Training and Practice Revenues

- Overemphasis on treating or fixing presumably homogeneous "disorders" may detract from a potentially more valuable effort to understand what caused the problem originally, what contingencies now maintain it (12), how treatment influences biopsychosocial processes to produce desirable behavior change, and what changes are needed to address more complex, comorbid problems (13).
- Efforts to standardize treatments potentially support progression toward a "dumbing down" of treatment that will enable therapy to be delivered by paraprofessionals or by computers.

How might the EBBM movement address these concerns?

We propose that the best answer is for those skeptical of the EBBM movement, from practitioners to scientists, to join researchers in the EBBM movement. Understandably, practitioners often chafe at the perceived arrogance with which researchers deliver pronouncements about how to perform scientifically sanctified therapy. The felt lack of reciprocity in such exchanges is a major source of provocation, and a sorry one that ultimately disadvantages all constituencies. As initiators of clinical trials, investigators stand to benefit from involving expert, experienced clinicians in the intervention design and implementation phases of clinical research (14). Also valuable are the insights of those scientists whose skepticism may provide insight into alternative change mechanisms or types of research that must be conducted to improve the evidence base.

The work of research scientists is enhanced by greater understanding of the complexity of decision-making processes that practitioners use when deciding how to work with typical cases. The work of practitioners benefits from having a systematic base of research evidence that validates the use of effective treatment methods, discourages the use of ineffective ones, helps third party payers tell the difference be-

tween the effective and ineffective methods, and allows policy makers to make informed decisions about reimbursement issues. A collaboration forged between these co-existing forces will benefit both science and client care.

In short, we progress with eyes wide open into the development of EBBM, and also with great excitement about the prospects for diverse constituencies to benefit and learn from each other. The EBBM Committee has made valuable progress during the first two years of its tenure, and our work continues. For example, the committee is carrying out several projects that are intended to address the issues listed above. These projects include: a) creating a registry of intervention research studies, including information on how to access treatment manuals; b) expanding the focus from internal validity and RCTs to other methodologies and external validity issues with the help of new EBBM Committee member, Russell Glasgow, Ph.D., and the RE-AIM framework he and his colleagues have developed (www.RE-AIM.org); and c) by introducing EBBM concepts, their strengths and their limitations, to a number of peer-reviewed behavioral medicine journals.

We continue to welcome the participation of *Outlook* readers in the EBBM process. Comments about this article and/or the activities of the EBBM Committee can be sent at any time to Karina Davidson, Ph.D., EBBM Committee Chair, at karina.davidson@msnyuhealth.org. We look forward to working with the behavioral medicine community on these issues.

References

1. Beutler LE. David and Goliath: When empirical and clinical standards of practice meet. *Am Psychol* 2000; 55:997-1007.
2. Bernal G, Scharron-del-Rio MR. Are empirically supported treatments valid for ethnic minorities: Toward an alternative approach for treatment research. *Cultur Divers Ethni Minor Psychol* 2001; 7(4):328-42.
3. Wehr E. Evidence-based health care coverage for children: Proceed with caution. *Ambul Pediatr* 2001; 1(1):23-27.
4. Saver JL, Kalafut M. Combination therapies and the theoretical limits of evidence-based medicine. *Neuroepidemiology* 2001; 20(2):57-640.
5. Naylor CD. Grey zones of clinical practice: Some limits to evidence-based medicine. *Lancet* 1995; 245:840-42.
6. Tonelli MR. The limits of evidence-based medicine. *Respir Care* 2001; 46(12):1435-1440.

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coalitions. SBM also needs stronger marketing and better visibility and credibility among a variety of audiences and the general public. We must develop a media and communications presence, issue press releases about articles published by members, and make SBM content area experts available to the press.

3. Membership and Community Development Task Force, Martita Lopez, Chair. This group will help organize and expand SIGs, building a sense of community within SBM through activities like professional development, mentoring and enhanced networking, and liaison with other organizations.
4. Training and Leadership Development Task Force, Bob Kerns, Chair. This Task Force will address issues of life-long learning and lifespan career development (e.g. address needs of mid and later career development as well as early career, student, and fellowship development); expand the website with different types of training opportunities, develop course syllabi and models of improving the process of acquiring transdisciplinary and translational skills; expand mentoring program; partner with other organizations for accreditation and curriculum development; develop leadership training for asserting authority over what is behavioral medicine; create ambassadors for SBM; and enhance leadership skills at Board level.
5. Research to Evidence-based Practice Task Force, Karina Davidson, Chair. This Task Force would highlight issues of research-to-practice *Annals* and *Outlook*; liaison with organizations that can improve practice and influence policy; find out what data and types of studies are needed to convince gatekeepers to adopt evidence-based behavioral medicine into the mainstream of health care and public health; and consider the marketing and advocacy aspects of evidence-based research to practice.

This is a sample of more to come. The goal is to develop a mission and scope of work for each area, propose goals and objectives, and consider implementation mechanisms either within existing SBM structures or, if needed, recommend forming new structures. The Board will review the reports at its October meeting. We will keep you posted and welcome your input as we progress.

As further evidence of SBM's vitality, the quality and volume of submissions to *Annals* has been phenomenal. We are adding two issues per year to increase the number of publications accepted and to reduce publication lag. Bob Kaplan, the Associate Editors, support staff, Publications Committee, and many volunteer reviewers make it all possible. As I reported last time, the citation index for *Annals* has climbed to the level of the best, first tier, journals. We are also making plans to liaison more closely with our international society and are discussing ways to provide all SBM members with access to the electronic version of the international SBM journal. All this comes as part of your membership benefits in SBM. In response to member requests, we plan to distribute *Outlook* in hard copy to all members. We will also strive to improve audiovisual support (e.g., LCD projectors) at our annual convention as well as provide more refreshments than at previous meetings.

We have not had a dues increase for many years now and our dues are quite modest compared with other similar organizations. We continue to want to keep dues low for student members. After careful analysis by the Finance Committee and consideration by the Board, we have recommended a dues increase as well as a modest increase in the registration fee for the 2003 annual meeting. Subject to final approval by the Board, it looks like dues will be \$190 for full/associate members, \$80 for students/trainees, and \$150 for transitional and retirees. Convention registration will increase by \$25 for full/associate/retirees and \$15 for students/trainees. The six copies of *Annals*, hard copy distribution of *Outlook*, and improved convention support are all some of the additional benefits that a dues increase will provide. This is an investment in our future. We hope you understand and support these proposals. The vast majority of the increases are to offset the costs of the two additional issues of the journal and hard copy distribution of *Outlook*.

There are two advocacy and marketing issues of which you should be aware. First, on the research side this year is the final year of appropriating double-digit increases of the NIH budget. Congress and the Senate have indeed doubled the NIH budget over five years. For example the NCI budget has increased from a little over \$2 billion to \$4.7 billion for 2002-2003. Understandably, the climate in Washington now

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is to show what we and NIH have done with the money. There is a strong push for accountability. A business model is being applied to NIH and other areas of government. We are being asked to document the value and impact we have made to improve health and health care.

However, starting next year the Bush administration is proposing a 2 or 2.5 percent increase. This may sound reasonable on the surface (after a doubling of the budget) but you need to know it is problematic. Briefly, NIH has funded many more grants and the average cost per grant has gone up by about 40 percent. First time awards and K-awards for career development are being generously supported to increase the number of new scientists doing health research. Since a grant is usually funded for an average of four years, this ties up almost all the money in the out years until about 2006. A 2.5 percent increase will actually require serious cutbacks somewhere in the NIH budget (e.g. payline will drop well below 20th percentile for 2004-2006, or across the board cuts in already funded grants will have to be made). This would be particularly harmful for new investigators. It is estimated that at least a nine percent increase is needed next year just to break even and hold the payline at around the 22nd percentile. One argument to make to the Bush administration is that their small increase will pull the rug out and undo many of the things that are only just beginning to bear fruit (like increasing the number of young scientists going into behavioral medicine and the public health fields). You can advocate to your local representatives and those on Capitol Hill in the Appropriations Committees (e.g. Senators Specter and Harkin, who delivered on their promise to double the NIH budget, and others like Senators Frist and Reed). For more ideas see Jessie Gruman's excellent column in the July 2002 issue of *Good Behavior* (www.cfah.org) on balancing the research and applications portfolio; including behavioral applications in Medicare; and on how critical behavioral science is in translating the largess of a doubled NIH budget into real benefits for society.

Second and relatedly, with the government's business model of accountability, we also have to show that we are using the money wisely and that it will directly benefit the public. California, for example, has recently published some exciting data that their aggressive anti-tobacco campaign is now producing significant reductions in utilization and health care costs for both cardiovascular disease and cancer. This is of great interest to CMS (formerly HCFA) and others. They are also painfully aware of the coming bubble of aging baby boomers and what they will do to health care budgets in both the private

and public sectors. Insurers are also projecting and they know that they cannot afford to charge a family \$12,000 per year for health insurance. They are looking at defined contribution models. They want hard data on other ways that they can provide health improvement and hold down the burden and cost of chronic disease as the population ages. What an opportunity for us at SBM! But with more than 20 years and thousands and thousands of articles published, do we have prospective data from randomized trials on the impact of evidence-based behavioral interventions on health costs and utilization? The answer is almost none at the level needed to convince a CEO. We have lots of correlational data (e.g. from worksite health promotion and disease case management protocols). We know that those with risk factors like smoking, obesity, and sedentary lifestyle or those with poor adherence cost more and use more medical services than those who do not. This is not good enough. The data we do have will not convince hard-nosed government or insurance gatekeepers to put what we know into general widespread practice. We have work to do. We can make a difference in the world. Let's go forward as we sail into the 21st century.

Reference

Kahn RL, Prager DJ. Interdisciplinary collaborations are a scientific and social imperative. *The Scientist* 1994;July:12.

Education and Training (continued from page 5)

knowledge and skills that I gained at SCRDP in both health promotion and research methodology will be invaluable to me in my new position. I am indebted to a great many SCRDP colleagues for my fruitful career path.

3. What advice would you give future applicants to this program?

My advisor at SCRDP encouraged me to look for the intersecting opportunities to between health psychology/behavioral medicine and public health. I would advise future applicants to SCRDP to do the same and to look for other collaboration with researchers in other fields. The interdisciplinary environment at SCRDP provides a wonderful opportunity to creatively merge different academic fields and the rich concepts and methodologies developed within each. It is through this creativity that interesting and useful research will develop. ◆

Upcoming Educational Opportunities

December 9–15, 2002: *The Psychology of Health, Immunity and Disease—14th International Conference*. Marriott Beach and Golf Resort, Hilton Head, SC. Sponsored by NICABM. Forty (40) CE/CME credits. Contact: Rose-Marie Attenello (800) 743-2226 or Rose@nicabm.com or visit our website www.nicabm.com to register. For additional information, please write to NICABM, PO Box 523, Mansfield, CT 06250.

February 19-22, 2003: *Society for Research on Nicotine and Tobacco's 9th Annual Meeting*. Sheraton New Orleans Hotel, New Orleans, Louisiana. Inquiries: Tel: 608-836-3787 ext. 144. Email: srnt@tmahq.com. Web: <http://www.srnt.org>

March 19-22, 2003: *Bridging Boundaries in Behavioral Medicine: Transdisciplinary, Translational, Transcultural, and Transnational—24th Annual Scientific Sessions of SBM*. Grand America Hotel, Salt Lake City, Utah. Please contact the National Office for more information.



Join SBM in Salt Lake City, March 19-22, 2003 for the 24th Annual Scientific Session entitled, "Bridging Boundaries in Behavioral Medicine: Transdisciplinary, Translational, Transcultural, and Transnational".

Salt Lake City combines unparalleled natural beauty and the amenities of a major metropolitan area with the friendliness of a small, western city. Nestled in a valley at the base of two alpine mountain ranges, Salt Lake City is a thriving cultural center with a diverse mix of night spots, a world-class symphony and opera, art galleries, historic sites, great restaurants and shopping.

Spring in Salt Lake City is mild enough for golf in the valley, while offering great skiing at one of the 10 major ski resorts that are within 90 minutes of the conference center. Spend a day at the conference and enjoy the local night life (it's as easy to get a drink as it is to order dinner), or go night skiing and dine in the spectacular mountains of nearby Park City.

For more information on what Salt Lake City has to offer, please contact the Salt Lake Convention and Visitors Bureau, 90 South West Temple, Salt Lake City, UT 84101. Tel: (801) 521-2822. Web: www.visitsaltlake.com.

EBBM (continued from page 8)

7. Rosenstock L, Lee LJ. Attacks on science: The risks to evidence-based policy. *Am J Public Health* 2002; 92(1):14-18.
8. Chambless DL, Ollendick TH. Empirically supported psychological interventions: Controversies and evidence. *Annu Rev Psychol* 2001; 52: 685-716.
9. Henry WP. Science, politics, and the politics of science: The use and misuse of empirically validated treatment research. *Psychother Res* 1998; 8:126-140.
10. Beutler LE. Manualizing flexibility: The training of eclectic therapists. *J Clin Psychol* 1999; 55(4):399-404.
11. Wilson KG. Science and treatment development: Lessons from the history of behavior therapy. *Behav Ther* 1997; 28(4):547-558.
12. Davison GE. Being bolder with the Boulder model: The challenge of education and training in empirically supported treatments. *J Clin Couns Psychol* 1998; 66(1):163-167.
13. Beutler LE & Martin BR. Prescribing therapeutic interventions through strategic treatment selection. *Cogn Behav Prac* 2000; 7:1-17.
14. Martell CR. & Hollon SD. Working together on shifting ground: Researcher and clinician collaboration in clinical trials. *Behav Ther* 2001; 24(7):144-146.

SBM 2003 Call for Papers—Deadline: September 13, 2002

Individuals are invited to submit their research for presentation at the 2003 SBM Annual Meeting & Scientific Sessions through the Call for Papers. Submissions from transdisciplinary, transcultural, transnational and translational groups are strongly encouraged. All else being equal, preference will be given to submissions whose authors represent multiple disciplines. All proposals must be submitted electronically no later than 12:00 midnight (CST) on **Friday, September 13, 2002**. Please carefully review the submission instructions available on the SBM website (<http://www.sbmweb.org>). All abstracts must be submitted on-line through the SBM website.

SBM will feature a meritorious student poster session on the first evening of the meeting (Wednesday, March 19, 2003). To facilitate the choice of posters for this session, student members must identify their student status on the submission form. The posters selected for this poster session will be seen twice—once in the opening poster session and again in the poster session relevant to the topic of the poster.

Submission of a proposal implies a commitment to present at the meeting and all presenters will be expected to register (pay) for the conference. Notification of acceptance or rejection of abstracts will be e-mailed to the designated corresponding author no later than January 1, 2003.

Presentation Descriptions

Each of the following are acceptable presentation formats:

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 presentations 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 to 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 strongly encouraged.

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

Topics (Please read all possible headings before choosing):

Each corresponding author will be asked to select one of the following topics in which his or her abstract submission will be reviewed (tracks are grouped with topics that may be presented at the same session):

- [Addictive Behaviors¹](#)
- [Arthritis/Pain/Psychoneuroimmunology/AIDS](#)
- [Lifespan Issues](#)

We want to encourage submissions that have a developmental/aging/lifespan approach. Addictive behaviors, arthritis, pain or psychoneuroimmunology issues that are the primary focus of the abstract, and do not meet one of the above topics, should be submitted under the appropriate topic heading here. If the abstract focuses on these issues, regardless of the specific disease of interest, please use the lifespan topic heading.

- [Cancer](#)

Any abstracts relating to cancer, including the prevention of cancer, should be submitted under this topic area.

- [Cardiovascular Disease¹](#)
- [Obesity/Diabetes/Physical Activity](#)

Any abstracts relating to cardiovascular diseases, or the major lifestyle risk factors for these diseases, should be submitted under this topic area.

- [Population Health/Health Policy¹](#)
- [Prevention](#)

Any abstracts that focus on population health or health policy, even if also relevant to a specific disease, should be sent under the population health topic. If an abstract is primarily about prevention, and the secondary topic is a specific disease, then the abstract should be submitted under the prevention topic. If the primary aim of the abstract is to further knowledge about cancer, for example, but there are also prevention aspects to the abstract, the abstract should go to cancer.

- [Transcultural Issues¹](#)
- [Translational Research to Practice](#)
- [Interactive Health Communication](#)

We want to encourage submissions under these topics, so if the abstract is focused on diversity or health disparities, but is also about cardiovascular disease prevention, we would prefer that the topic submission be under transcultural issues. Similarly, if there is a strong translation angle in an abstract, please use that topic heading.

¹Posters for all of these topics will be presented at the same poster session.

CLASSIFIEDS

Postdoctoral Fellow in Pain Rehab Rehabilitation Professionals Grand Rapids, MI

Postdoctoral Fellow in Pain Rehabilitation with the Pain, PEAK and Headache Programs at Rehabilitation Professionals in Grand Rapids, MI. This full-time, 2-year position prepares the fellow with the clinical responsibilities and experiences necessary to work as part of an interdisciplinary team. *Duties:* evaluation and testing; group, individual, and family therapy; biofeedback; and participation in interdisciplinary team conferences for patients with chronic pain and headache, and sub-acute pain (PEAK). *Training opportunities:* individualized training and supervision, potential for research involvement, attend/present at Grand Rounds through Mary Free Bed Hospital & Rehabilitation Center. *Requirements:* Ph.D./Psy.D. from an APA accredited psychology program and internship, Michigan Doctoral Limited License or license eligible. Previous experience with pain populations and biofeedback strongly preferred. **Review of applications begins immediately and will continue until filled, with an anticipated start date of September 1, 2002 or sooner if possible.** Salary ranges from \$28,000-\$30,000 (depending on pain experience) per year plus benefits. Applicants should submit a letter of application, vita, sample pain evaluation, and three letters of reference to: Edmund O'Connor, Ph.D.; Director & Chief Psychologist; c/o Mindy Zito, Rehabilitation Professionals, 350 Lafayette St. SE, Suite 500; Grand Rapids, MI 49506. E-mail: Edmundo@rehabpros.com.

Chronic Pain Psychologist Kaiser Permanente Oakland, CA

Kaiser Permanente, a leader in health care, is seeking a Psychologist for its Oakland facility. In this opportunity to work with a dynamic, energetic multidisciplinary team, you will evaluate, diagnose and treat adult member patients referred to the Chronic Pain Care Management Program. You will utilize Health Psychology and Behavioral Medicine treatment approaches which may include crisis intervention, brief psychotherapy, psychoeducation groups, case management and program evaluation. Psychological and neuropsychological testing may also be incorporated.

This position requires a Ph.D. in Clinical Psychology from an accredited college or university and a current valid Psychologist License. Two years post licensure experience, including one year in a Chronic Pain Program. High level of experience with cognitive-behavioral and behavioral medicine treatment approaches. Familiarity with theories of chronic pain management and pharmacology for chronic pain. Good working knowledge of general psychiatry, chemical dependency and psychopharmacology. Experience in diagnosis, crisis intervention, brief individual and group psychotherapy, teaching, consultation and collaboration with medical personnel. Experience administering and interpreting psychological and neuropsychological tests. Skills in hypnosis, biofeedback and movement modalities are highly desirable. Fluency in Spanish preferred. Must be able to work in a Labor/Management Partnership environment.

Kaiser Permanente offers a competitive salary, excellent benefits and employment incentives that enhance your career and support you personally and professionally.

To apply, please send your resume via fax to Kaiser Recruitment Services at (510) 675-6852 or email to joyce.a.bishop@kp.org.

Postdoctoral Fellowship University of Virginia Charlottesville, VA

Postdoctoral fellowship positions are available at the Behavioral Medicine Center at the University of Virginia to work on NIH-funded projects investigating behavioral aspects of diabetes. These projects include development of interventions to 1) reduce risk of auto accidents due to hypoglycemia and 2) improve parent ability to teach children with diabetes to regulate glucose levels. Applicants should have a PhD in Clinical Psychology, Health Psychology, or related field. Prefer candidates with experience in behavioral diabetes research. Submit a letter of interest, CV, and list of references to Linda Gonder-Frederick, Ph.D., Behavioral Medicine Center, Box 800223, University of Virginia Health System, Charlottesville, VA 22903. Phone (434) 924-5316. Fax (434) 924-0185.

Assistant Professor Health and Social Behavior Harvard School of Public Health Dana Farber Cancer Institute Boston, MA

The Harvard School of Public Health (HSPH) and the Dana-Farber Cancer Institute (DFCI) are initiating a search for a tenure track Assistant Professor of Health and Social Behavior. The successful candidate will have a background in behavioral intervention research for chronic disease prevention, early detection, and/or treatment, preferably with experience working with socioeconomically and/or ethnically diverse populations. Experience with cancer patient populations is also desirable. Demonstrated success in grant-funded research will be a strong consideration.

A doctorate in psychology, public health, or a related field is required. The individual chosen will teach and advise students in the doctoral and master's programs within the Department of Health and Social Behavior at HSPH, and may play a role in on-going efforts targeting health communication.

The successful candidate will be a member of DFCI's Center for Community-Based Research, and Dana-Farber/Harvard Cancer Center's Risk Reduction Program, and will be encouraged to build collaborative studies with members of the center's disease programs. Numerous additional opportunities exist for interdisciplinary and collaborative work between HSPH, DFCI and Harvard's other teaching hospitals.

Please submit a curriculum vitae, a statement of research plans, and the names of three references to: Search Committee, DFCI; Harvard School of Public Health; Department of Health and Social Behavior, Kresge 709; 677 Huntington Avenue, Boston, MA 02115.

Harvard University and the Dana-Farber Cancer Institute are committed to increasing the number of women and minority faculty, and encourage applications from such candidates.

Outlook

Executive Committee

David B. Abrams, PhD

President, 2002-2003
Centers for Behavioral & Prev Med
The Miriam Hospital
CORO Bldg Ste 500, One Hoppin Street
Providence RI 02903
Ph: (401) 793-8005
EM: david_abrams@brown.edu

Michael G. Goldstein, MD

Past President, 2002-2003
Bayer Inst. for Health Care Communication
400 Morgan Lane
West Haven CT 06516
Ph: (203) 812-3261
EM: michael.goldstein.b@bayer.com

Linda C. Baumann, PhD, RN

President-Elect, 2002-2003
UW Hospitals & Clinics
600 Highland Ave K6/342
Madison WI 53792-2455
Ph: (608) 263-5272
EM: ljbauman@facstaff.wisc.edu

Edwin B. Fisher, PhD

Secretary/Treasurer, 2000-2003
Div of Health Behavior Research
Washington University
4444 Forest Park Ave Ste 6700
St. Louis MO 63108-2212
Ph: (314) 286-1901 • EM: efisher@im.wustl.edu

Judith K. Ockene, PhD

Member Delegate, 2000-2003
Univ of Massachusetts Med School
Department of Medicine
55 Lake Avenue North
Worcester MA 01655
Ph: (508) 856-2316
judith.ockene@umassmed.edu

Robert T. Croyle, PhD

Member Delegate, 2001-2004
National Cancer Institute
6130 Executive Blvd, EPN/4060
Bethesda MD 20892-7326
Ph: (301) 435-6816 • EM: bc136e@nih.gov

Kenneth A. Wallston, PhD

Member Delegate, 2002-2005
Vanderbilt University
429B Godchaux Hall
Nashville TN 37240
Ph: (615) 343-3317
ken.wallston@mcmail.vanderbilt.edu

Council Chairs

Education & Training

Robert D. Kerns, PhD
robert.kerns@med.va.gov

Membership

Martita A. Lopez, PhD
lopez@psy.utexas.edu

Publications & Communications

Alan J. Christensen, PhD
Alan-christensen@uiowa.edu

Scientific & Professional Liaison

Robin E. Mockenhaupt, PhD
rem@rwjf.org

Scientific and Professional Liaison

Associate Chair
Richard W. Seidel, PhD
rseidel@carilion.com

Committee Chairs

Nominating

Peter P. Vitaliano, PhD
pvital@u.washington.edu

Development

David K. Ahern, PhD
dahern@theabacusgroup.com

Finance

Barbara S. McCann, PhD
mccann@u.washington.edu

Program

Karina W. Davidson, PhD
karina.davidson@msnyuhealth.org

Long-Range Planning

Michael G. Goldstein, MD
michael.goldstein.b@bayer.com

Program Oversight

Marc D. Gellman, PhD
mgellman@miami.edu

Electronic Communications

Susan M. Sereika, PhD
ssereika@pitt.edu

Outlook Editor

Cheryl L. Albright, PhD
cheryl.albright@stanford.edu

Annals Editor

Robert M. Kaplan, PhD
rkaplan@ucsd.edu

Executive Staff

Executive Director

Elizabeth A. Klipping
7600 Terrace Ave Ste 203
Middleton WI 53562
Phone: (608) 827-7267 Ext 143
Fax: (608) 831-5485
bklipping@reesgroupinc.com

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Behavioral Medicine
7600 Terrace Avenue, Suite 203
Middleton, WI 53562



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