
Encyclopedia of Behavioral Medicine

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Encyclopedia of Behavioral Medicine

With 99 Figures and 46 Tables

 Springer

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Opening Quotations

Some of the unhealthful behaviors that make the greatest contribution to the current burden of disease are cigarette smoking, the abuse of alcohol and drugs, the overeating and underexercise that produce obesity, and Type A behavior. Unfortunately, these behaviors are stubbornly resistant to change and discouragingly subject to relapse. Thus, for behavioral scientists to promise to achieve too much too soon is to court disastrous disillusionment. But any contributions that behavioral scientists can make to reduce any of them will have highly significant implications for health.

Miller, N. E. (1983). Behavioral medicine: Symbiosis between laboratory and clinic. *Annual Reviews of Psychology*, 34, 1–31.

As behavioral medicine researchers, we must become more directly involved in translating gains in the science of clinical and community (disease) prevention to gains in public policy. We have an unprecedented window of opportunity given the growing recognition at all levels of health care and government that clinical and community interventions that promote and support health behaviors will be essential for success in reducing the nation's most prevalent and costly health problems and untenable health-care costs and disparities. This is the kind of opportunity that propelled the founders of our field 25 years ago, and we are better prepared than ever in our history to seize it.

Ockene, J. K., & Orleans, C. T. (2010). Behavioral medicine, prevention, and health reform: Linking evidence-based clinical and public health strategies for population health behavior change. In A. Steptoe (Ed.), *Handbook of behavioral medicine: Methods and applications* (pp. 1021–1035). New York: Springer.

The extent to which behavioral medicine can become a successful part of health care delivery systems will in large part depend upon investigators in the field being able to master clinical translational research, moving from efficacy to effectiveness with a high ratio of benefit to cost. . . . Because Behavioral Medicine has been constructed based on the understanding of relationships among behavior, psychosocial processes and sociocultural contexts, the field is well-positioned to take

a leadership role in informing future health care policies. The field of Behavioral Medicine appears to have a bright, important future.

Schneiderman, N. (2012). A personal view of behavioral medicine's future. This volume.

Foreword

Early Developments in the Field of Behavioral Medicine

At the editors' request, this Foreword provides a personal account of the early development of behavioral medicine. With many colleagues, I was fortunate to play a role in bringing together behavioral and biomedical sciences in such a way that the synergism resulting from this interaction resulted in ideas, conceptualizations, models, and ultimately interventions that were truly different from preexisting approaches to health and illness. As noted in the Preface, the contents of this encyclopedia bear witness to the manner in which behavioral medicine has matured during the past 30 years, illustrating current activities in the domains of basic research, clinical investigation and practice, and public health policy.

In 1963, I was a psychology intern in the Department of Medical Psychology at the University of Oregon Medical School (now called the Oregon Health Sciences Center). Under the guidance of Joseph Matarazzo, chair of the department, the relationship between medicine and psychology was undergoing an historic realignment. Joe had a fascinating and exciting perspective on the nature of such relationships and on psychology's potential to make those relationships mutually rewarding for both patients and practitioners. I consider myself fortunate to have been "in the right place at the right time" when a request came from the Division of Cardiothoracic Surgery for psychological and psychiatric consultation on a problem that was mystifying the surgeons.

Under the leadership of Albert Starr, surgeons were performing groundbreaking procedures known as "open heart surgery" on patients who had been incapacitated, typically for many years, by their heart conditions. These surgeries offered them the opportunity to reclaim their earlier lives as active members of society, and, in some cases, to take on roles that were denied to them since childhood. Paradoxically, following surgery, many patients, rather than expressing their gratitude for the opportunity to be "made whole again," become angry, depressed, and suicidal. With colleagues from the departments of psychology and psychiatry, we begin a search for the "underlying mental illness" that must have been uncovered by the stress of the surgery. However, rather than discovering the presence of psychiatric illness, it was found that the *absence of psychological strength* was a key factor associated with the behavioral anomalies. This finding led to the development of a program to psychologically evaluate a candidate's readiness to undergo surgery and to better prepare psychologically vulnerable candidates for the recovery experience.

My dissertation on psychological adjustment following open heart surgery led me to the Division of Psychosomatic Medicine in the Department of Psychiatry at the Johns Hopkins University School of Medicine, and to the application of psychodynamic theory to problems as diverse as diabetes, cardiovascular disease, cancer, and transgender surgery. In 1974, I accepted a position at the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH) as chief of a unit that would eventually become the Behavioral Medicine Branch. The first year was *very* difficult since I was essentially the only behavioral scientist at NHLBI, and no one understood exactly what I was supposed to do and why I was there. However, I considered this to be a singular opportunity to bring the behavioral and biological sciences together, if only we could come up with a model, a theoretical framework that made sense to both groups and was scientifically viable.

Good problem-solving strategies break the overall problem down into more manageable pieces. The first was to address the lack of fundable studies in the NHLBI portfolio, which comprised a total of four regular research grants (R01s). The institute director commented to me that behavioral scientists must not be very good scientists as their applications were routinely disapproved or failed to make the funding payroll. However, investigation revealed that the 25 “behavioral” applications submitted for the current round were scattered among 14 different study sections. Two issues became evident: (1) many of the behavioral applications were biologically weak and (2) the multidisciplinary expertise necessary to properly review applications that had both behavioral and biological endpoints was missing from the various study sections to which the applications had been assigned.

It became clear that two efforts were needed. First, it was necessary to make both biomedical and behavioral scientists aware of the need for a collaborative “biobehavioral” approach involving top-tier expertise in both areas when submitting grant applications. Second, it was necessary to campaign within the NIH for a study section that could provide relevant peer review for these biobehavioral applications. NIH agreed to convene an “ad hoc” temporary review group (the Behavioral Medicine Study Section) to assess whether there really was a need for such a group. Clearly there was, since 3 years later the study section was formally chartered as a standing study section.

Meanwhile, it became obvious that to develop and sustain meaningful research programs within the NIH would require organized, active, outside constituencies of scientists and clinicians who could provide peer review to all aspects of NIH program development and scientific leadership, i.e., partnerships with academic and professional societies that could provide advice and guidance were needed. With specific regard to biobehavioral research, the need for credible representation led us to Neal Miller, a behavioral scientist who was well known to, and highly respected by, the biomedically oriented Institute staff. Neal had performed landmark studies of learning and biofeedback. He was persuaded to serve as keynote speaker for the 1975 NHLBI Working Conference on Health Behavior. The 3 days of intensive deliberations between senior behavioral and biomedical scientists were

summarized and published as a proceedings to serve as the public blueprint for the Institute's future biobehavioral scientific agenda.

Along with the 1977 Yale Conference on Behavioral Medicine sponsored by NIH, this meeting set the stage for a 1978 organizational meeting hosted by David Hamburg, President of the Institute of Medicine of the National Academy of Sciences. The deliberations of this two-day gathering of highly respected biomedical and behavioral scientists gave birth to two organizations, the Society of Behavioral Medicine (SBM) and the Academy of Behavioral Medicine Research (ABMR). The founding leaderships of these organizations agreed to be complementary rather than competitive in mission and purpose, with SBM serving both scientific and professional interests of all persons interested in the field and ABMR being a small invitation-only group of distinguished senior scientists dedicated to identifying and promoting "gold standard" science in behavioral medicine. SBM created a newsletter that became the high-quality scientific and professional journal *Annals of Behavioral Medicine*, and ABMR published an annual volume, *Perspectives on Behavioral Medicine*, summarizing scientific presentations at their annual retreat meeting.

During this early developmental period, a potentially divisive issue arose among the cadre of behavioral medicine pioneers: Exactly what is meant by the term "behavioral medicine?" Agreement on a common definition of the field was clearly necessary. One contingent defined behavioral medicine primarily as "behavior modification with medical patients," while another contingent took a broader view which included the aforementioned aspect, but challenged both the behavioral and biomedical communities to join forces as "the interdisciplinary field concerned with the development and integration of behavioral and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation." The latter became the agreed-upon definition by both behavioral medicine organizations and survived intact for a decade until the founders of the International Society of Behavioral Medicine proposed in 1990 that "psycho-social" be added to "behavioral and biomedical" to better align the definition with the charters of the emerging European national and regional behavioral medicine organizations.

The underlying concepts of behavioral medicine are perhaps thousands of years old. Prior to the emergence of behavioral medicine in the mid to late 1970s, the most recent effort to capture mind-body interactions can be attributed to those engaged in research and practice of psychosomatic medicine. Primarily psychodynamically oriented psychiatrists, they began to take note of behavioral medicine, initially identifying the fledgling organizations with the first definition mentioned previously (behavior modification with medical patients) whereas their interests were principally focused upon how the principles of psychoanalysis could be applied to the treatment of somatic disorders. However, as the second definition gained traction among the rank and file of the behavioral medicine community, psychosomatic medicine scientists and practitioners were challenged to either resist or join forces with the newcomers. Over the next decade, it became clear that, while

psychoanalytic theory was intellectually provocative, it lacked the tools of modern day science to test its theories, and hence such theorizing remained in the realm of speculation. Behavioral medicine, on the other hand, took full advantage of the new monitoring instrumentation generated in large part by the U.S. space program's need for ambulatory monitoring of physiological processes via telemetry. Such instrumentation facilitated exploration in the laboratory and in real life of how variation in biological processes may be stimulated by behavioral inputs, as well as how biological processes may impact behavior. Over the next 20 years, the membership of the American Psychosomatic Society and the organization's flagship journal, *Psychosomatic Medicine*, shifted their emphasis to one indistinguishable from that of organized behavioral medicine.

During this time, biobehavioral scientific programs were beginning to develop within several institutes at NIH, and funding for biobehavioral research increased exponentially, albeit unevenly. An inter-institute Committee on Health and Behavior was formed, with Matilda White Riley from the National Institute on Aging as its first chair. This committee served in an advisory capacity to the individual institute directors as well as to the NIH director, becoming the precursor for the Office of Behavioral and Social Science Research, Office of the Director, NIH, which is now under the leadership of Robert Kaplan, past president of both SBM and ABMR.

Although research funding was increasing, another challenge became evident: Where were the *training* resources to support new entrants to the field? Typically, research training programs in the biological and biomedical sciences relied on NIH support; it became obvious that such resources needed to be developed to establish a pipeline for "biobehavioral" scientists-in-training to receive both individual and institutional support. Donald Cannon, chief of the training branch at NHLBI, the unit responsible for supporting both types of awards at NHLBI became interested in the issue, and met with senior behavioral medicine researchers who could apply for such awards based on their research programs and the resources of their institutions. Over the next 3 years, 12 institutional awards were made to support cardiovascular behavioral medicine training for both behavioral/social scientists and biomedical/biological scientists, further solidifying the scientific base for the field.

These developments within the United States were mirrored in other parts of the Western world, with emerging organizations in several European countries grappling with the relevance of the behavioral medicine concept to their perspectives on health and illness. In the mid-1980s, discussions at an SBM annual conference with international attendees resulted in an agreement to form an International Society of Behavioral Medicine (ISBM) dedicated to supporting the emergence of new as well as existing national and regional behavioral medicine organizations. Funds to support several planning meetings were provided by the Rockefeller family and the Duke University Behavioral Medicine Research Center, and the first International Congress of Behavioral Medicine took place in 1990 in Uppsala, Sweden. The International Society (members are national or regional societies rather than individuals) represented seven national and regional societies at this first

meeting. *International Journal of Behavioral Medicine* became the scientific outlet for behavioral medicine studies of international relevance. By 2012, 26 (and counting. . .) national/regional societies from every continent formed the membership of ISBM.

Finally, one important element of the behavioral medicine paradigm deserves mention, as it is illustrative of the basic conceptual infrastructure of biomedical and behavioral *integration*. Often, biomedical and behavioral scientists pose the question of treatment efficacy in terms of which is more effective, pharmacologic or behavioral treatments. Rather than “either/or,” the behavioral medicine position is to determine how both treatments, perhaps in combination or in sequence, may provide a more effective treatment than either alone. Several examples come to mind, for example, smoking cessation, hypertension treatment, and cardiovascular disease prevention. Using a drug to lower blood pressure or cholesterol can provide a window of opportunity to use non-pharmacologic strategies to maintain lowered blood pressure/cholesterol, thereby reducing/eliminating reliance on the medication. Smoking cessation programs typically are more effective when both behavioral and pharmacologic treatments are combined to sustain cessation. Pharmacologic agents are typically more efficient at creating the desired effect but may have long-term side effects; behavioral treatments may be less efficient at creating change but may be more effective at sustaining conditions that have been achieved pharmacologically. The bottom line is straightforward: Rather than asking which approach is superior, use the strengths of both areas of science creatively to achieve a sustainable treatment effect that minimizes unwanted side effects and could not be attained by using either approach by itself.

In summary, I have tried to provide a few personal insights into the events leading to the formalization of behavioral medicine as a viable, vibrant perspective on the promotion of health and the prevention and treatment of disease and as the multidisciplinary inquiry into the underlying mechanisms involving brain, genes, behavior, and physiology/biology. I hope that this provides a useful historical “snapshot” as you immerse yourself in the impressive array of accomplishments chronicled in this encyclopedia.

The following Foreword by Neil Schneiderman presents a personal view of behavioral medicine’s future.

Stephen M. Weiss

Foreword

A Personal View of Behavioral Medicine's Future

The field of behavioral medicine appears to have a bright, important future. That is because contemporary scholarship in behavioral medicine has been constructed upon a solid foundation consisting of basic biological and behavioral science, population-based studies, and randomized clinical trials (RCT). The edifice that is emerging derives its strength and form from its interdisciplinary structure. It derives its reach and potential for future growth from its selection of key building materials and tools including the study of etiology, pathogenesis, diagnosis, treatment, rehabilitation, prevention, health promotion and community health. Because behavioral medicine approaches to prevention, treatment, and health promotion involve important relationships among behavior, psychosocial processes, and the sociocultural context, the roof of this structure will both consist of and benefit from the support of informed patients and populations, thoughtful educated health-care providers and involved communities.

Let us begin with population-based studies. During the second half of the twentieth century, epidemiological studies described important associations between traditional risk factors on the one hand and morbidity and mortality on the other, but elucidated relatively few of the variables mediating these associations. In my own area of cardiovascular disease (CVD) research, considerable attention has now focused upon obesity, inflammation, insulin resistance, oxidative stress, and hemostatic mechanisms as potential mediators. In this respect, traditional large-scale multicenter population-based studies have done a better job of describing the association between traditional risk factors (abnormal lipids, hypertension, smoking, diabetes, age) and CVD and their putative mediators than they have in describing the associations between biobehavioral, psychosocial, and sociocultural risk factors and CVD, and their mediators. However, this is now beginning to be addressed in such National Institute of Health (NIH) multicenter studies as the Hispanic Community Health Study/Study of Latinos (HCHS/SOL), Coronary Risk Development in Young Adults (CARDIA), and Multi-Ethnic Study of Atherosclerosis (MESA). Some of these studies are employing such preclinical measures of disease as carotid intimal-medial wall thickness and plaque by ultrasonography and coronary artery calcium by computed tomography to examine the progression of disease processes relating risk factors and CVD.

The examination of preclinical markers of disease as mediators between biobehavioral, psychosocial, and sociocultural risk factors on the one hand and chronic diseases on the other has been facilitated by the availability of

commercial assays. These assays have permitted the study of biomarkers involved in preclinical disease processes including adhesion molecules, pro-inflammatory cytokines, and oxidative stress in both animal and human studies. We can expect that many further advances will be made in the development of commercially available research methods and that they will increase our understanding of relationships among biobehavioral, psychosocial, and sociocultural risk factors and the pathophysiology of CVD, cancer, and other chronic diseases.

Although a wide range of epidemiological studies have called attention to potentially modifiable risk factors, and most chronic disease risk factors are modifiable (Yusuf et al., 2004), it should be recognized that chronic disease outcomes are the result of the joint effects of risk genes, the environment, and behavior upon these risk factors. One can therefore expect that on the basis of genomic analyses, future studies will begin to identify the extent to which particular individuals are vulnerable to specific risk factors and diseases and may be candidates for targeted behavioral as well as pharmacological interventions. Thus, in the coming era of personalized or tailored medicine, we may expect that behavioral medicine research will play an important role both in understanding the antecedents of disease that interact with genomic predispositions and in selecting appropriate treatment interventions.

The future for behavioral medicine science playing an essential role in population-based observational studies appears to be inevitable. This will occur because both the fields of behavioral medicine and epidemiology have expanded their horizons based upon important scientific findings. Early epidemiological studies focused upon hygiene and infectious diseases. By the middle of the twentieth century, epidemiological studies were examining the prevalence of multiple risk factors (e.g., smoking, dyslipidemia, hypertension) and disease outcomes (e.g., coronary heart disease [CHD], stroke, cancers). However, more recent multicenter observational studies have increasingly identified behavioral, psychosocial, and sociocultural variables as potential risk factors for chronic diseases. Thus, future multicenter observational studies will likely include demographic (e.g., racial/ethnic background, sex, socioeconomic status, neighborhood environments), psychosocial (e.g., temperament and personality, marital and work stressors, social support), lifestyle (e.g., medication adherence, diet, sleep, physical activity, smoking), biomarkers (e.g., immune, inflammatory, hemostatic, imaging), and genomic factors that influence disease outcomes. An important trend that is likely to increase in the future is the development of consortia of population-based studies (e.g., Population of Architecture using Genomics and Epidemiology: PAGE) whose purpose is to investigate mature genetic variants associated with complex diseases in large diverse populations. Such consortium studies are each beginning to include well over 100,000 participants. Perhaps most importantly the constituent studies and the consortia will be able to follow participants over the course of many years, providing important incidence data that will allow us to examine the specific causal variables influencing the course of disease. This represents an important opportunity for behavioral medicine scientists.

Traditional observational studies have often reported findings using odds ratios, which provide estimates (with confidence interval) for the relationship between binary variables. Such studies have also permitted assessment of the effects of other variables on specific relationships using regression analyses. More recently, scientific interest in understanding the role of potential mediators of relationship between risk factors and disease outcomes has increasingly led to the use of analytic techniques such as structural equation modeling including path analysis, which until now have mostly been used in the social sciences. We can expect that a dramatic improvement in our understanding of the mediators between risk factors and disease outcomes will occur in the coming years.

The completion of the Human Genome Project in 2003 led to an increased interest in gene-environment interactions within the behavioral medicine research community. Such interactions occur when genetic factors affect measured phenotypes differentially, for example, when men with the E4 allele of the apolipoprotein E gene (APOE) were shown to have an increased smoking related risk for CHD events (Humphries et al., 2001). Other studies have shown that the interaction of the alpha 2B-adrenergic receptor polymorphism with job strain is related to elevated blood pressure (Ohlin et al., 2007), and several other studies have related gene polymorphisms with cardiovascular reactivity to mental challenge. Most behavioral studies that have examined gene-environment interactions have been carried out on relatively small samples, but it appears inevitable that a large number of high-quality, well-powered, gene-environment studies of direct relevance to behavioral medicine will be initiated during the next few years.

In addition to the structural genomics exemplified in gene-environment interaction studies, functional genomic studies are also likely to become of increasing interest to behavioral medicine investigators. Briefly, functional genomics focuses on the basics of protein synthesis, which is how genes are “switched on” to provide messenger RNA (mRNA). Francis Crick, who along with James Watson discovered the structure of the DNA molecule, originally thought that each gene, consisting of a particular DNA sequence, codes for one specific mRNA molecule that in turn codes for a specific protein (Crick, 1970). Subsequently, it became evident that after being transcribed, most mRNA molecules undergo an editing process with some segments being spliced out. In this way, a gene can lead to more than one type of mRNA molecule and consequently more than one type of protein. Thus human cells, which each contain about 25,000 genes, are able to synthesize more than 100,000 different proteins.

Epigenetics refers to the altering of gene function without changes in the DNA sequence. This can occur either by methylation of the DNA itself or by remodeling of the chromatin structure in which the DNA is packaged. Because of these processes, in utero exposure to nutrition or social factors can cause permanent modification of gene expression patterns that may lead to increased risk of mental disorders, diabetes, cancer, or cardiovascular diseases (Jirtle & Skinner, 2007). As an example of how social exposure in early life can have long-duration epigenetic and phenotypic influences, Meaney and Szyf (2005) showed that neonatal rodents who received high

levels of postpartum nurturing revealed diminished cortisol responses to stressful experiences when they reached adulthood. Such studies are providing a strong basis for future epigenetic behavioral medicine research.

The important advances made by observational and mechanistic studies relevant to behavioral medicine research are paralleled by a few RCT that have provided evidence that behavioral interventions aimed at modifying lifestyle or psychosocial variables can help prevent morbidity and/or mortality in high-risk populations. Thus, for example, the Diabetes Prevention Program trial (Knowler et al., 2002) in the United States and the Finnish Diabetes Prevention Trial (Tuomilehto et al., 2001) each observed that lifestyle interventions targeting weight loss and an increase in physical activity can reduce the incidence of diabetes in prediabetic patients. Based upon the success of these trials, the NIH has sponsored Look AHEAD (Action for Health in Diabetes), an RCT that is scheduled to last for 11.5 years. This trial is specifically examining whether an intensive lifestyle intervention similar to that used in the Diabetes Prevention Program can prevent major CVD events in obese participants with type 2 diabetes. Whereas the diabetes prevention projects and the Look AHEAD trial are essential for establishing that lifestyle interventions can prevent type 2 diabetes and reduce CVD risk in diabetic patients, subsequent investigation will be needed for us to learn how such interventions can be applied to clinical practice.

Although psychosocial-behavioral RCT conducted upon patients following major adverse coronary events (e.g., myocardial infarction) have yielded both positive and null results, the three major trials that have reported positive results share important similarities that differentiate them from the studies reporting null results (Friedman et al., 1986; Gulliksson et al., 2011; Orth-Gomér et al., 2009). Thus, the participants in the three major RCT reporting positive results all received group-based cognitive behavior therapy that included, in addition to cognitive behavior therapy, relaxation training and attention to lifestyle problems. The interventions all included up to 20 sessions over a year or more and used therapists specifically trained to use behavior change techniques in order to conduct behavioral interventions with cardiac patients. Treatment began at least several months after the CHD event and patients were followed up for an average of 4.5–7.8 years. Although the trials yielding positive results each studied between 237 and 862 participants, the size of each study was insufficient to permit assessment of the efficacy of specific intervention components, the role of potential biological mediators or the applicability of the intervention to populations differing in terms of important demographic characteristics. Thus there is still a need to replicate and amplify the results of the previously successful trials in rigorous, large-scale, multicenter RCT that can identify the demographic, psychosocial, and lifestyle variables that influence specific behavioral and biological determinants of risk.

In the future, evidence-based medicine will play an ever-increasing role in clinical health care. The extent to which behavioral medicine can become a successful part of health-care delivery systems will in large part depend upon investigators in the field being able to master clinical translational

research, moving from efficacy to effectiveness with a high ratio of benefit to cost. Thus, for example, the Diabetes Prevention Program (Knowler et al., 2002) showed that in high-risk patients, a lifestyle intervention reduced the incidence of diabetes significantly better than a pharmacological intervention and that both interventions were superior to a placebo condition. However, the lifestyle intervention was labor intensive and required considerable effort to get participants to maintain improvement. In contrast, maintaining adherence to taking a pill once daily may pose a less daunting task. However, recent advances in web-based intervention research may level the playing field. Thus, automatic e-mail reminders, phone or e-mail based consultations with a health-care professional, interaction with web-based programs, and the instant availability of important specially tailored information on an interactive website can all help patient adherence. To the extent that weight loss programs that involve diet and exercise do more than only decrease the risk of type 2 diabetes but also improve other aspects of CVD risk, such programs are particularly valuable in terms of health promotion.

The RCT that decreased morbidity or mortality rate in CHD patients each required 20 or more group-based sessions (Friedman et al., 1986; Gulliksson et al., 2011; Orth-Gomér et al., 2009). When amortized over the length of the 4.5–7.8 year follow-up period, however, the cost compares favorably with that of most drugs also used in treatment. Participating in 20 or more sessions also poses a personal cost and some hardship for many people. However, the implementation of interactive web-based group sessions using both sound and video could obviate the need for most face-to-face meetings and allow interpersonal interactions to continue over long periods of time. It therefore seems apparent that the rapid advances taking place in science and practice during the internet era will prove helpful in making behavioral medicine an important ingredient of future health-care systems.

Future health-care systems could be strengthened by well-informed patients and by health-care providers who are grounded in behavioral medicine concepts as well as clinical medicine. Attention to the human and health-influencing aspects of neighborhoods (i.e., the built environment) are also important and dependent on informed public policy. Because Behavioral Medicine has been constructed based on the understanding of relationships among behavior, psychosocial processes, and sociocultural contexts, the field is well positioned to take a leadership role in informing future health-care policies. The field of behavioral medicine appears to have a bright, important future.

Neil Schneiderman

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Preface

The establishment, advancement, and maturation of the field of behavioral medicine bears witness to interest among research scientists, clinicians, and policy makers in psychological, behavioral, and social influences on health and disease from the perspective of both the individual patient and global public health. It has become increasingly clear that such influences may negatively impact health and well-being and, equally importantly, that behavioral interventions may be protective and curative.

Neal Miller (1909–2002), an American psychologist and recipient of the National Medal of Science in 1964, is often credited as being the founder of behavioral medicine. He made significant contributions to our understanding of the relationship between reinforcement mechanisms and the control of autonomic behavior, and in pioneering the field of biofeedback, which is used successfully today to treat a variety of medical conditions. The original definition of behavioral medicine was developed at the Yale Conference on Behavioral Medicine and later published by Gary Schwartz and Stephen Weiss (1977):

“Behavioral medicine” is the field concerned with the development of behavioral-science knowledge and techniques relevant to the understanding of physical health and illness, and the application of this knowledge and these techniques to diagnosis, prevention, treatment and rehabilitation.

While this definition remains the cornerstone of our interdisciplinary and integrative field, developments in many relevant subfields have advanced at rapid rates, and whole new specialties have arisen. This evolution was well exemplified by the publication in 2010 of the *Handbook of Behavioral Medicine* (Steptoe, 2010). Relevant knowledge and understanding of issues of interest in behavioral medicine is now contributed by the disciplines of and expertise from anthropology, behavioral and molecular genetics, behavioral science, biostatistics, clinical medicine, cultural studies, epidemiology, health economics, general medicine, genomics, psychiatry, psychology, physiology, public health and public health policy, and sociology, to name but a few. It was therefore considered an opportune and appropriate time to create the *Encyclopedia of Behavioral Medicine*, whose publication coincides with the 12th International Congress of Behavioral Medicine, held on August 29th to September 1st, 2012, in Budapest, with attendees representing multiple disciplines and many countries around the globe. The theme of

the meeting is “Behavioral Medicine: From Basic Science to Clinical Investigation and Public Health,” the theme around which this *Encyclopedia* has been developed.

Accordingly, the *Encyclopedia* contains entries falling into three categories or domains that represent issues of interest: basic research, clinical investigation and practice, and public health and public health policy. The domain of basic research addresses the key questions of mechanisms of action, both in terms of how behavior can have a deleterious impact on health and how a change in behavior can be beneficial, either preventively or therapeutically. The domain of clinical investigation and practice translates this basic knowledge into clinical interventions on a patient-by-patient basis. Finally, the domain of public health and public health policy takes a broader view of how behavioral medicine research and interventions can impact the health of populations at the community, regional, national, and global levels. This includes addressing the system-wide/public education and advocacy/political activities that are needed to facilitate maximum benefits at the global level.

It can immediately be seen that behavioral medicine is indeed a multidisciplinary and interdisciplinary field. Researching mechanisms of action requires a detailed level of human biology, starting from the molecular genetic level and progressing from cellular to organ to whole-body study. A thorough understanding of environmental interactions with biological functioning is also necessary. The domains of basic research and clinical investigation and practice are linked by the increasingly important concept of translational medicine, that is, how to translate our mechanistic knowledge and understanding into successful clinical interventions most effectively and efficiently. The final challenge, likely the most challenging but ultimately providing the greatest benefit, is to address these interventions at the public health level.

Within these overarching categories, it is possible to group together various entries into categories of interest to individual readers or groups of readers pursuing their own research in cross-cutting areas. One example might be the impact of behavioral medicine research and interventions across the life span, that is, taking a life cycle approach. Entries in the *Encyclopedia* such as Children’s Health Study, Elderly, End-of-Life Care, Geriatric Medicine, Life Span, Obesity in Children, and Successful Aging might be instructive in this case.

A second example might be looking at genetic predisposition to the deleterious impact of environmental factors and, equally of interest, to the therapeutic benefit of certain behavioral medicine interventions. Entries of interest here might be Family Studies (Genetics), Gene-Environment Interaction, Gene Expression, Genome-wide Association Study, and Twin Studies. While not always intuitively obvious, one of the most powerful ways to study the effects of environmental (behavioral) factors on a phenotype of interest (e.g., a given disease state or condition of clinical concern) is to study genetic influence on that phenotype (Plomin et al., 1997). Having done so, it is possible to remove from consideration the individual variation attributable to genetic influence and hence to focus on variation attributable to

environmental and gene-environment interaction influences. We are certain that readers will find many such groupings of entries relevant to their own interests and research.

Additional evidence of the growth of the discipline of behavioral medicine is provided by the fact that training in the field can be found in universities around the world, ensuring that the next generation of researchers and practitioners will be trained by current experts. Before going on to specialize in behavioral medicine research or clinical practice, individuals often receive their terminal degrees in disciplines such as medicine, public health, nursing, and psychology. Such diversity is a tremendous strength in this interdisciplinary field.

Like all such printed endeavors, the *Encyclopedia* proves a “snapshot in time” of its subject. Research during the past 30 years has provided the solid foundation from which future advances will be made, and it will be of great interest to all of us in behavioral medicine to follow its further development. We are grateful to Stephen Weiss for providing a Foreword entitled “Early Developments in the Field of Behavioral Medicine,” which reviews important events in the discipline’s evolution, and to Neil Schneiderman for providing a Foreword entitled “A Personal View of Behavioral Medicine’s Future,” which provides an insightful view of likely trajectories and benefits of our discipline. We hope that subsequent editions will provide additional snapshots in due course.

Miami, July 2012

Marc D. Gellman and J. Rick Turner

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My journey in the interdisciplinary field of behavioral medicine has allowed me to delve into the fields of epidemiology, medicine, neuroscience, psychology, pharmacology, physiology, and public health. Throughout this entire journey, my mentor and teacher, Neil Schneiderman, has shaped my career. From my time as an undergraduate student, through graduate school, a postdoctoral fellowship, and on to becoming a faculty member, I have been fortunate to be by Neil's side. For this, first and foremost, I would like to acknowledge and dedicate this *Encyclopedia* to him.

To my wife Jill Turner, who has been by my side throughout the development of the *Encyclopedia*, I could not have done this without your patience and support.

MDG

I moved to the United States in 1987 to join Paul Obrist's group at the University of North Carolina at Chapel Hill. I met Neil Schneiderman shortly

thereafter, and he has been a great source of personal and professional support since that time. I am delighted that Marc has dedicated the *Encyclopedia* to him. I would like to acknowledge the scientific training I received at the University of Sheffield and the University of Birmingham. My doctoral work in cardiovascular psychophysiology and cardiovascular behavioral medicine was conducted in Birmingham under the supervision of Doug Carroll, with John Hewitt providing additional guidance in the fields of Statistics and behavioral genetics.

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JRT

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Since 1986, he has been continuously funded by the National Institutes of Health, primarily in the area of cardiovascular behavioral medicine. Dr. Gellman has published in a variety of journals including: *Psychosomatic Medicine*, *Health Psychology*, *Annals of Behavioral Medicine*, *Psychophysiology*, and others. Dr. Gellman currently serves on the editorial advisory board for the McGraw-Hill *Annual Editions: Drugs, Society, and Behavior*. He previously served on the editorial board of the Sage Publications scientific book series Behavioral Medicine and Health Psychology from 1997 to 2004, edited by J. Rick Turner, his co-editor for this *Encyclopedia*.

Dr. Gellman is a former board member of the International Society of Behavioral Medicine, serving as its secretary 2004–2008 and chair of the communications committee 2000–2004. From 2004 to 2006, he served as program co-chair for the International Congress of Behavioral Medicine. Dr. Gellman is a longtime board member of the Society of Behavioral

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In his spare time, he is an avid bicycle rider and enjoys “out of car experiences” with his wife Jill, touring numerous countries on their tandem bicycle. He is a wine aficionado, an enthusiast of rock, jazz, and reggae music, and occasionally lectures on the influence drugs have on culture, being inspired by his attendance at the historic Woodstock Music and Art Festival in 1969.



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Dr. Turner is particularly interested in the development of drugs for type 2 diabetes mellitus. He has testified before two U.S. Food and Drug Administration committees, the Endocrinologic and Metabolic Drugs Advisory Committee and the Drug Safety and Risk Management Advisory Committee, and is working with both biopharmaceutical companies and regulators to expedite the development of drugs for this disease. He is also an advocate of increasing adherence to drugs for all chronic diseases, including diabetes, by greater use of knowledge and strategies developed in the field of behavioral medicine.

Dr. Turner is on the editorial board of the peer-reviewed *Journal for Clinical Studies* and is editor-in-chief of the peer-reviewed *Drug Information Journal*.

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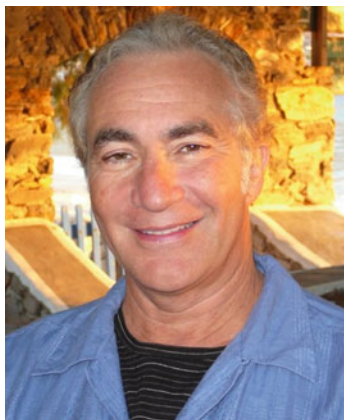
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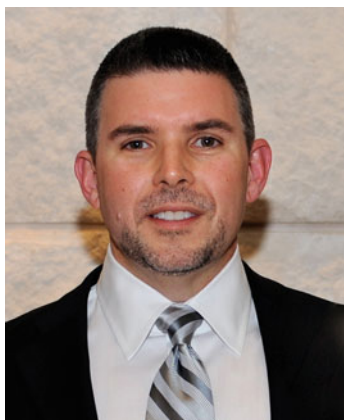
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