SOC Index Policy

There comes friction from some people over the issue of asking the SOC questions. This friction mostly comes from smokers who are ashamed to ask if someone else smokes while the air around them is clearly filled with the stench of burnt paper and the fingers are yellow from the disgusting residue of nicotine. Tobacco is associated with one out of every four deaths as it is the world’s largest killer. And the addiction of the smoke twists the minds of the addicts to lie and distort reality with rationalization and imbalanced excuses. We start with education, responsibility, awareness of a lifestyle analysis (SOC).

Biofeedback has survived recently by embracing lifestyle analysis and there is a $25 CPT code fee for doing the SOC Index. Personal Responsibility is the core of the biofeedback practice. Professionalism requires and mandates personal responsibility. If a biofeedback health care practitioner does not want to ask lifestyle questions or the SOC Index then he should look for a vocation elsewhere. MacDonald’s is always hiring and there are many job opportunities in the hotel and house cleaning field.

CPT CODE 90875 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient) e.g. insight oriented, behavior modifying, lifestyle education, stress reduction modalities) approximately 20-30 minutes.
Now as to the operation of the device.

If you needed to measure a person’s weight is it not a fair question to ask “Do you have any bricks in your pockets???, How much do your shoes weight??”. Is there something weighing you down??”. Well that is what the SOC is. We are seeing what is weighing our patient down.

If there are two dissimilar metals in your mouth such as mercury fillings the water in your mouth makes a battery. If we are going to measure the subtle body electric we need to know if there are fillings in the mouth upsetting the body electric. This is important, I mean very important.
If you smoke the smoke interferes with your oxygen transport. Every body function in every cell is less when you smoke. Your wellness is less with each puff. To compensate the body must take energy away from other life functions to compensate. So we if we lie and do not tell the device we smoke the measurement is less accurate. We cannot get a true hydration and oxygenation reading without the SOC Index. This is important, I mean very important.

**SMOKING EFFECTS**

**Immediate & Short-term**
- Smelly hair
- Less oxygen to the brain
- Stroke
- Blindness
- Yucky skin, smelly breath & stained teeth
- Gum disease, leading to tooth loss
- Mouth & throat cancer
- More coughs & colds
- Increased heart rate & blood pressure
- Less oxygen to lungs. This causes shortness of breath, reduces fitness and can also cause an asthma attack in asthmatics.
- Stained fingers

**Medium & Long-term**
- Heart disease, heart attack
- Emphysema (walls of lung tubes collapse)
- Lung cancer
- Stomach ulcers
- Skin becomes dry, discoloured & wrinkled
- Bladder cancer
- Infertility, impotence
- Poorer muscle tone

After Smoking all cellular functions are weakened, Everything is Less, You are Less

Smoking interferes with Oxygen Transport Thus making the body Compensate other Body Functions in order to Survive.

To Properly Measure the Body Electric we need to know how much you smoke so we can see how much your addicted body has to compensate to maintain homeostasis in the face of oxygen depletion

The other measures all have some bearing on education, insight, wellness, health and personal responsibility. But many have direct bearing on the accuracy of the treatment. If you are concerned with accuracy and efficacy then you should do the SOC Index.

You may agree with Dr House and say that all people lie. But we should not build lies into the system by not reporting the SOC Index. your car was designed to have 4 or 5 lug nuts on each wheel and you could take off one on each wheel and still drive, but you are not safe doing things away from the original
design. The original design was for the SOC index to be a crucial part of the process. Behavioral medicine is our start as we encourage personal responsibility.

Exercise is important as is stress reduction and of course awareness is key. Know Thyself and then Physician Heal Thyself. Awareness and enthusiasm is needed for health care.

“The practice of sport is a human right. Every individual must have the possibility of practicing sport, without discrimination of any kind and in the Olympic spirit, which requires mutual understanding with a spirit of friendship, solidarity and fair play.” —Olympic Charter

What we need to do is start our health care process of with the awareness and education of who is the big problem with health and wellness. Whether people lie or not is not as important as us making a statement of awareness on the main industries controlling us while making disease. The SOC Index sets the record straight from the start about the root cause of over 85% of the disease in the world today. This due diligence should not be disdained just because you are an addict of smoke and you are afraid to ask others if they are addicted slaves as well.

The SINthetica drug companies offer symptom control not cure and any SINthetic is an insult to the body making dependency and side effects. SINthetic drugs are a last resort. There is a time for all things under heaven, but we should try natural health care methods and behavior change before resorting to allopathic SINthetic drugs. We never tell a person or patient to get off of a drug or to disobey a doctor patient covenant. But informed understanding of the side effects and consequences of the SINthetic can be helpful. http://syntheticissynthetic4u.com
No one starts to smoke because they want or like the first taste. Anyone saying this is lying to themselves. Everyone starts to smoke out of emotional and or sexual insecurity. They want to be like someone else or there is peer pressure. The part of the brain that resists peer pressure is in the prefrontal cortex and it does not fully develop till you are 18. This is why we set it as the “Age of Consent” in most cultures. Our governments prohibit purchase and use of the highly addictive tobacco products till you are the age of consent. It is clearly murder and reckless endangerment to leave the cigs on the table and let a child become addicted beneath the legal age of consent. No prosecutor has ever taken this clear as a bell case, but hundreds of parents have been prosecuted for reckless endangerment for not giving their child meat. So we see the effect of BIG MONEY of the Ultra-Rich. And this needs to be exposed even if our patients lie.
Big Sugar creates another vast amount of disease. This needs exposure of the science and awareness to change the diet. And maybe asking the question "How much Processed Sugar do you Use??" will become more important to you after reading and watching.

http://youtu.be/Ah88giejCTU
UCSF Scientists Declare WAR on Sugar in Food

Erin Allday, Chronicle Staff Writer

02/01/12

Like alcohol and tobacco, sugar is a toxic, addictive substance that should be highly regulated with taxes, laws on where and to whom it can be advertised, and even age-restricted sales, says a team of UCSF scientists. (University of California San Francisco)

In a paper published in Nature on Wednesday, they argue that increased global consumption of sugar is primarily responsible for a whole range of chronic diseases that are reaching epidemic levels around the world. The health care expense of sugar caused diseases is massive.

Sugar is so heavily entrenched in the food culture in the United States and other countries that getting people to kick the habit will require much more than simple education and awareness.
Understanding the Risks of any Surgery

If you are planning to have surgery your biggest concern should be the final outcome. Will your life be improved by the procedure or do the risks outweigh the rewards? No surgery is risk free, but understanding the possible complications can help you make a better decision.

Common Surgical Risks:
1. Anaesthesia Complications During Surgery
   Most problems that arise during surgery are the result of the surgery, not the sedation for the procedure. While uncommon, there are very serious complications that can occur if a patient has a reaction to the anesthetic drugs. Most problems associated with anesthesia are related to the process of intubation, or inserting the breathing tube.

2. Bleeding Problems During Surgery
   Some bleeding is expected during surgery, but bleeding beyond the normal amount can make a transfusion necessary.

3. Blood Clots Caused by Surgery
   Blood clots, often referred to as deep vein thrombosis (DVT), are a significant risk of surgery.

Death Due to Surgery
All surgeries, whether elective or absolutely necessary, carry a risk of death. A surgery that requires stopping the heart will have a higher risk than a surgery to remove cancer, but both can still result in death.

4. Delayed Healing After Surgery from drug use or immune suppression

5. Difficulty Breathing After Surgery from the ventilator

Infections After Surgery and anti-biotic’s side effects

Popularity and perils of liposuction

Liposuction, which removes fat, has become the most common plastic surgery procedure in the United States. But there are risks.

► Most common plastic surgery procedures

Listed by number of surgeries in the U.S. in 2001:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liposuction</td>
<td>385,000</td>
</tr>
<tr>
<td>Eyelid surgery</td>
<td>246,000</td>
</tr>
<tr>
<td>Breast augmentation</td>
<td>217,000</td>
</tr>
<tr>
<td>Nose reshaping</td>
<td>177,000</td>
</tr>
<tr>
<td>Face lift</td>
<td>117,000</td>
</tr>
</tbody>
</table>

Source: American Society for Aesthetic Plastic Surgery

► Most frequent fatal complications in liposuction

Blood clots 23.1%
Abdominal perforation 14.6%
Anesthesia complications 10%
Fat embolism 8.5%
Cardio-respiratory failure 5.4%
Massive infection 5.4%
Unknown/confidential 28%
Hemorrhage 4.6%

Note: Percentages do not add up to 100% because of rounding.
Source: Plastic and Reconstructive Surgery, January 2000
75% of Heart Surgeries are Avoidable
50% of Cesarian Sections are Avoidable
50% of Tonsilectomies are Avoidable
25% of Angioplasty is Avoidable
50% of Myingotomies are Avoidable
45% of Back Surgeries are Avoidable
35% of Hysterectomies are Avoidable

Organs often Wrongfully Removed from the Body

Adenoids

Tonsils

Gall Bladder

Thymus

Spleen

Intestine parts

Kidney

Ovaries

Appendix

Uterus

We need to Educate our Patients of the Dangers of Premature Surgery
People do not drink enough water, they do not exercise regularly, and they are under too much stress. Lethargy, confusion, unawareness, depression abound. We need to educate people on how lifestyle and ignorance makes disease. Simply asking these questions can help.
4 White Deaths

White Sugar
Salt
Pork Fat (the other white meat)
White Flour

Nelson Method of Medicine

1. Reduce causes of disease
2. Rebuild organs and tissue destroyed by causes
3. Unblock the blockages of flow
4. Treat symptoms NATURALLY
5. Metabolic and Constitutional Treatment of the individuality of the Patient
FLOW OF TREATMENT and CURE

1. Reduce or Remove the Cause of Disease
   Stress       Toxicity
   Lack of Awareness   Trauma
   Heredity       Pathogens
   Mental Factors   Perverse Energy
   Allergies      Def or Excess of Nut

2. Treat the Organs effected or diseased
3. UnBlock the Blockages To Flow of Life
4. Reduce Symptoms and all Suffering Naturally
5. Treat Constitutional and Metabolic
   Tendences to disease patterns or habits

Prof Nelson - Desiré Dr. János (Hans) Selye
Towards a new Safe and Effective truly Modern Medicine

HEALTH IS EASE OF FLOW
Stressors block Flow, Stress is more than Just personal stress.
Stress Reduction is the key to Medicine.

When the stressor or stressors weaken the defenses of the body, the weakest link of the body
(from nature or nurture) is most prone to distress and thus disease.
Muscles
Use Them or
Lose Them

Exercise is a Nutrient, our Bodies are designed to chop wood, cook, hunt and carry water and then have sex.

Exercise. It's cheaper than medical bills.

It's hard to beat a person that never gives up.
- Babe Ruth
We will do this right this time and we will insist on standardized training and professionalism in doing lifestyle in our biofeedback.

So stop lying and tell your patients to stop lying to themselves and the device. Even if you are a drunken chain smoker hooked on coffee and drugs, still do the SOC with your patients. Be a Teacher, Healer, Professional, and help people to deal with the causes of disease.

Use the device as it was designed to be used. If you care about your results, if you care about your patients, if you care about you family, if you care about your business, if you just plain care,

**THEN Do the SOC.**

**Case Closed.**
The word 'Doctor' comes from the Latin word 'Eductor' which means 'to teach'.

Thomas Edison said that the doctor of the future will teach the patient how to live and how to eat, exercise and meditate.

The Eductor is a Biofeedback Teacher

PROFESSOR DESIRÉ DUBOUNET
THE DEVELOPER
The Society of Behavioral Medicine (SBM) and public policy advocacy: a call to action

Paul Estabrooks, PhD, Sherry Pagoto, PhD, Jennifer Otten, PhD, RD, Lori Piibert, PhD, Amy Stone, Abby King, PhD, Kathy Goggin, PhD, Karen Emmons, PhD

ABSTRACT
In 2010, the Society of Behavioral Medicine heightened its priority to take an even more active role in influencing health-related public policy. Here we discuss the importance of behavioral medicine presence in public policy initiatives, review a brief history of SBM’s involvement in public policy, describe steps SBM is now taking to increase its involvement in health-related public policy, and finally, put forth a call to action for SBM members to increase their awareness of and become involved in public policy initiatives.

KEYWORDS
Public policy, Behavioral medicine

THE IMPORTANCE OF PUBLIC POLICY ADVOCACY FOR BEHAVIORAL MEDICINE RESEARCH
Advocacy can be defined as attempting to influence public policy through education, lobbying, or political pressure. As fewer dollars get spread across important federal, state, and local public health initiatives, the importance of advocating for the inclusion of evidence-based behavioral medicine research into programs, guidelines, and policies has never been greater. Preventable chronic conditions such as heart disease, cancer, obesity, HIV/AIDS, and diabetes account for 75% of the estimated $2 trillion annual health care costs in the US. Behavior is central to the prevention, development, and management of these diseases. Smoking, poor diet, sedentary lifestyle, alcohol intake, and risky sexual practices are directly related to the development of chronic diseases. Key behaviors in the prevention and management of chronic diseases include healthy diet, physical activity, medical regimen adherence, and stress management. Behavior is at the foundation of health, and therefore, behavior change is paramount in reducing the health care burden.

Evidence is mounting that behavioral interventions with individuals, families, organizations, and environments can prevent and/or delay disease, impact disease outcomes, improve disease management, and reduce health care costs. For example, brief smoking cessation counseling has been found to be cost-effective, and in concert with other cessation approaches, tobacco tax increases, clean indoor air laws, and counter-marketing campaigns have led to dramatic reductions in adult and youth smoking rates and concomitant reductions in premature deaths and billions of dollars in excess cost [1, 2]. In another example, programs promoting modest weight loss and physical activity have been shown to prevent diabetes in those at increased risk, substantially outperforming medication treatment [3, 4]. Ensuring that this type of evidence finds its way into funded initiatives, programs, and policies is critical to the health of the nation.

Implications
Practices: SBM is positioned to respond to and help shape policies relating to health care delivery given the weight of evidence for behavioral medicine practices. Policies relating to greater coverage for and access to preventive services and behavioral health would greatly impact behavioral medicine practice.

Policy: Steps are outlined for how SBM and its members can influence health policy, thereby increasing the impact of the field on the health of individuals and communities.

Research: SBM is positioned to respond to and help shape policies relating to public funding of behavioral and population health research.

LONG-TERM IMPACT
The Society of Behavioral Medicine envisions directing evidence-based advocacy toward protecting and promoting the health of the public. Our 2,000 members—psychologists, health care providers, and public health, behavioral, and policy scientists—are experts on behavioral and environmental changes that can improve the public’s health and reduce health expenditures. To enhance the impact of our work on public health, we need to ensure our voices are heard
PRESIDENTIAL ADDRESS

The Challenges of Future Behavioral Medicine

Johannes Siegrist

To a large extent, behavioral medicine originates from the United States, and more specifically from the scientific traditions of pragmatism and behaviorism. The core notion of individual learning, mastery, and development embedded in these traditions has lent support to an almost exclusive concern with individual behavioral modification. However, individual mastery and welfare are increasingly threatened by powerful adverse socioeconomic and sociocultural developments, especially by growing social inequalities in health and by expanding social disintegration. Social differentials in morbidity and mortality are documented even in the most economically advanced countries where health-damaging lifestyles (e.g., cigarette smoking, diet) and stressful conditions of relative deprivation in occupational life and elsewhere contribute to the observed pattern. In addition, detrimental effects on health produced by social disintegration are manifest, most notably in societies that undergo rapid socioeconomic change. Implications of these developments for future behavioral medicine are discussed at the level of scientific analysis and of preventive and therapeutic intervention.

Key words: behavioral medicine, behavioral modification, social inequalities, social disintegration

Johannes Siegrist, Institute of Medical Sociology, University of Düsseldorf, Düsseldorf, Germany.
This article was presented as the opening address by the President of the International Society of Behavioral Medicine (ISBM) at the Fourth International Congress of Behavioral Medicine, Washington, DC, March 13, 1996.

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Behavioral Medicine and the Health of Our Nation: Accelerating Our Impact

Karen Emmons, Ph.D.

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Abstract

Purpose A key goal of this paper is to illustrate the impact of behavioral medicine on the factors that influence population health. A second goal is to consider the delicate balance between relevance and excellence as we bring our science to bear on important social and public health problems. If we are to increase the translation of our evidence and accelerate our impact, we must increase our relevance while maintaining excellence in our scientific methods.

Methods What are the pressing questions facing those that would like to use our work, and how can we increase our relevance to theirs? We must work on the marriage of relevance and excellence—use rigorous methodologies, but be flexible in our approach, using study designs and methods that will get rapid yet rigorous answers to the questions that are facing practice and policy settings.

Conclusion We have the tools and the knowledge to impact the health of our nation.

Keywords Behavioral Medicine · Impact · Translation

Introduction

In terms of the history of science, behavioral medicine is a very new field, just over three decades old. This is particularly notable when one considers the many contributions made by behavioral medicine researchers and practitioners. As is typical of most fields as they emerge, an extensive focus was initially placed on establishing the field’s credibility and gaining acceptance. However, it is important to occasionally take a step back and focus on the field as a whole—its contributions and impact, as well as its continued potential to influence the health of our nation.

This paper has two goals. The first goal is to illustrate the impact that behavioral medicine has had on our understanding of the factors that influence population health. A brief review of behavioral medicine’s short history is a good reminder of the large and continually growing body of evidence that has accumulated. However, it is important for our field to also consider how to accelerate its relevance to both practice- and health-related policy, while at the same time maintaining our tradition of excellence. The second goal of this paper is to consider this delicate balance between relevance and excellence as we bring our science to bear on important social and public health problems. I will argue that relevance is key to successful translation of our evidence base in ways that can influence population health.

A Rapid Trajectory

The field of behavioral medicine, and its premier society, the Society of Behavioral Medicine, were established in the 1970s. Although the history of behavioral medicine has been recently reviewed [1, 2], it is worth noting the very rapid pace at which evidence supporting the development of the field accumulated. In 1982, the Institute of Medicine report entitled “Health & Behavior: Frontiers of Research in the Biobehavioral Sciences” [3] identified and integrated a range of research and identified promising areas, or “scientific opportunities,” for future development. This report noted the importance of both behavioral and social factors on health and health outcomes. For example,
<table>
<thead>
<tr>
<th>NUMBER OF PATIENTS/TYPE OF DISORDER/REFERENCE</th>
<th>INTERVENTION</th>
<th>LENGTH OF FOLLOW-UP</th>
<th>OUTCOME MEASURE</th>
<th>FINDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>117 patients with mild essential hypertension(^{70})</td>
<td>12 sessions, 45 minutes twice weekly, of breathing-relaxation training and biofeedback</td>
<td>1 year</td>
<td>Patients whose systolic or diastolic blood pressure decreased by &gt;10% from baseline (%)</td>
<td>66%</td>
</tr>
<tr>
<td>48 patients with mixed coronary heart disease(^{71})</td>
<td>Lifestyle program of diet, exercise, stress management, smoking cessation, and group psychological support</td>
<td>5 year</td>
<td>Cardiac hospitalizations per patient</td>
<td>0.82</td>
</tr>
<tr>
<td>585 patients with myocardial infarction(^{72})</td>
<td>Scheduled interaction between case managers and patients after discharge: 14 nurses initiated telephone contacts; progress reports mailed to patients; and 4 individual nurse sessions of exercise testing, diet-drug therapy for hyperlipidemia, and smoking cessation</td>
<td>6 months after MI</td>
<td>Smokers who quit 2 months after MI (non-smoking status was biochemically confirmed) (%)</td>
<td>70%</td>
</tr>
<tr>
<td>52 patients with mixed coronary artery disease(^{73})</td>
<td>3 weekly groups of pain management and relaxation training, cognitive reframing, and problem solving</td>
<td>1 month</td>
<td>Weekly chest pain frequency (range 0 to &gt; 5 times/day)</td>
<td>1 less</td>
</tr>
</tbody>
</table>

\(^{1}\)CABG = coronary artery bypass grafting; METS = multiples of energy consumption; MI = myocardial infarction; PTCA = percutaneous transluminal coronary angioplasty.

\(^{1}\)P < 0.01

\(^{1}\)P value not available.
Behavioral Medicine: A Voyage to the Future

Francis J. Keefe, Ph.D.

Abstract This paper discusses trends and future directions in behavioral medicine. It is divided into three sections. The first briefly reviews key developments in the history of behavioral medicine. The second section highlights trends and future directions in pain research and practice as a way of illustrating future directions for behavioral medicine. Consistent with the biopsychosocial model of pain, this section focuses on trends and future directions in three key areas: biological, psychological, and social. The third section describes recent Society of Behavioral Medicine initiatives designed to address some of the key challenges facing our field as we prepare for the future.

Keywords Pain - Biopsychosocial model - Behavioral medicine

Introduction

The field of behavioral medicine has journeyed far over the past 30 years. Whether we have been in the field since its inception or just recently joined it, each of us has a perspective on where behavioral medicine has been and where it is going. That perspective is unique and very much shaped by our experiences and background. Recall the tale of the blind men who sought to learn what an elephant was like by touching it [1]. One blind man touched the leg of the elephant and concluded that an elephant was a pillar. A second touched the tail and claimed the elephant was like a rope. A third touched the trunk and reported the elephant was like a tree branch. A fourth touched the ear and said the elephant was like a hand fan. A fifth touched the belly and concluded the elephant was like a huge wall. The blind men argued about the elephant, almost coming to blows because each felt he was right. At that point, a wise man that had been watching and listening to the blind men spoke up and told them that each was right, since the elephant had all of the features described. All of the blind men were satisfied since each was comforted to know he was right.

This paper speculates on the voyage that behavioral medicine will likely take in the future. It is always a hazardous proposition to imagine the future. Like the blind men, each of us has a unique perspective on the future that is shaped by our own experience. My view is unique and very much influenced by 30 years of experience in one corner of the world of behavioral medicine: pain research and practice. I have had the good fortune of coming into this area at a time when it was in its relative infancy and having the opportunity to watch it grow and mature. In addition, I have been fortunate to have spent most of my career at Duke University, one of the leading behavioral medicine research institutions. This has given me the chance to develop professional and personal relationships with leaders in many different fields of behavioral medicine and to compare developments in my own area to those in many other areas of behavioral medicine.

This paper is divided into three sections. The first section briefly reviews key developments in the history of behavioral medicine. The second section highlights trends
Society of Behavioral Medicine (SBM) position statement: ban indoor tanning for minors

Sherry Pagoto, PhD,1 Joel Hillhouse, PhD,2 Carolyn J Heckman, PhD,3 Elliot C Coupes, PhD,4 Jerod Stapleton, PhD,5 David Buller, PhD,6 Rob Turrini, PhD,6 June Robinson, MD,7 Alan C Geller, MPH8

ABSTRACT
The Society of Behavioral Medicine (SBM), an interdisciplinary professional organization focused on the science of health behavior, in collaboration with the American Academy of Dermatology, the American Academy of Pediatrics, and a host of other national and international organizations in support of a total ban on indoor tanning for minors under the age of 18. According to the International Agency for Research on Cancer, artificial sources of ultraviolet radiation are in the highest category of carcinogens, joining tobacco and asbestos. Strong evidence links indoor tanning to increased risk for melanoma with repeated exposure during childhood being associated with the greatest increase in risk. Several countries and five US states have passed legislation banning indoor tanning in minors. We strongly encourage the remaining US states to do the same in an effort to protect children and prevent new cases of melanoma. SBM also strongly encourages research that explores the use of tanning beds in the home. Home-based indoor tanning has the potential to be especially dangerous given the complete absence of safety regulations. Children are currently protected from exposure to health-harming substances like tobacco and lead; thus, legislation protecting them from artificial sources of ultraviolet radiation is yet another important step forward in improving public health.

KEYWORDS
Skin cancer, Indoor tanning, Melanoma, Prevention, Health policy

The Society of Behavioral Medicine (SBM) is an interdisciplinary organization of scientists and clinicians focused on the science of human behavior as it relates to health and illness. SBM joins the US Department of Health and Human Services [1], US Food and Drug Administration (FDA) [2], American Academy of Pediatrics [3], American Medical Association, American Academy of Dermatology [4], Canadian Pediatric Society, [5], and the World Health Organization [6] in support of a ban on indoor tanning for minors. An indoor tanning ban for minors is indicated for the following reasons:

**Implications:**
**Practice:** Clinicians working with patients who engage in indoor tanning should educate them about the health risks and be aware that some tanners may develop a "dependency" on tanning that resembles substance dependence.

**Policy:** SBM proposes a ban on indoor tanning for minors under the age of 18 as a measure to reduce the prevalence of melanoma in the US.

**Research:** Research is needed to evaluate the impact of indoor tanning related policy as well as indoor tanning that occurs in non-legislated contexts, such as in the home.

- Research has clearly established that indoor tanning increases risk for both nonmelanoma [7] and melanoma skin cancers [6]. Indoor tanning has also been linked to serious eye damage [9, 10]. Artificial sources of ultraviolet (UV) radiation join tobacco and asbestos in the highest category of human carcinogens per the International Agency for Research on Cancer [6].
- Exposure to UV radiation in early life increases the risk for developing skin cancer. In a case-control study in Australia, adults under 40 who had 10 or more indoor tanning sessions in their lifetime had a twofold increase in the risk for developing melanoma by that age relative to people who had never turned indoors [11]. The increase in risk associated with 10 or more indoor tanning visits was fourfold for melanoma diagnosed between 18 and 29 years of age.
- In some tanners, tanning can develop into "tanning dependence," a pattern of tanning that bears resemblance to other substance dependencies. The suspected mechanism for tanning dependence is via the release of endogenous opioids when the skin is exposed to UV radiation [12]. Possible cases of tanning dependence are not uncommon, with rates ranging from 33 to 41% among tanning salon...
Theories in Behavioral Medicine

The scientific method is a cyclic process consisting of theories, hypotheses, observations, and conclusions. Scientists use theories to develop a specific hypothesis, which is subsequently tested in an empirical study: the observations in the empirical study result in a conclusion on the truth of the hypothesis and the need for adaptation of the theory. In the deductive approach, "theory" is the point of entry into the scientific cycle; development of the hypothesis and designing an empirical study are the next steps. In the inductive approach, one starts from empirical data; these observations lead to a theory, which is then empirically tested (de Groot, 1971). See Figure 1.

The field of behavioral medicine as a whole, with this IBM as an outstanding exponent, is witnessing more sophisticated use of theories. Traditionally, behavioral medicine has had a strong focus on gathering data in empirical research. In recent years, the need for theories facilitating the interpretation and integration of empirical findings is increasingly acknowledged. Without the integrative framework of theory, there is a risk of ending up with a set of loose facts which are difficult to interpret: theory facilitates the coherent interpretation of empirical findings. Furthermore, theory is conducive to identifying the next step in research (hypothesis and empirical study) given the state of knowledge in the field: theory facilitates scientific progress.

A scientific theory consists of a set of concepts and statements concerning a particular domain of reality. Requirements for a scientific theory include: (1) logical consistency of the concepts and statements; (2) hypotheses which can be empirically tested; (3) parsimony, i.e., preference for the least complex explanation for an observation; and (4) being restricted to a clearly defined domain of reality. These requirements enable the distinction between scientific theories and pseudo-theories.

In the field of behavioral medicine, several major theories or theoretical approaches exist. Some of these meet the requirements for a scientific theory and can be properly designated as a theory. Others are at an early stage of development and need to be developed further: these are best designated as a theoretical approach. Major theories and theoretical approaches in behavioral medicine are listed below.

**Theories on stress and emotional regulation.** These theories describe how the stress response is dependent on an external cue (stressor), the appraisal of the stressor, intermediate variables, and regulation of emotional responses. Selye (1956/1976), Lazarus and Folkman (1984), and Miller (1987) are publications which are important from a historical perspective. Recent examples in this journal of a study using the stress theory include Langelaan, Bakker, Schaufeli, van Rhenen, and van Doornen (2007) and Brown, Katzel, Neumann, Maier, and Waldstein (2007).

**Theories on personality and health.** These theories concern the role of personality in the development and prognosis of diseases. A classic but outdated example is Friedman and Rosenman (1959) on Type A behavior in cardiovascular diseases. A recent example is Denollet et al. (2006) on Type D behavior, also in cardiovascular disease.

**Theories on health behavior, health and disease.** These theories address the mechanisms explaining the relationship between health behavior (such as smoking, diet, and physical activity) and the development and prognosis of health and disease. In the field of physical activity/inactivity, Bouchard, Shephard, Stephens, Sutton, and McPherson (1990), Pate et al. (1995), and Vuori et al. (1995) have provided important input. A recent example is Veenhof et al. (2007).

**Social cognitive theories on health behavior.** This family of theories addresses how health behavior is determined by expectations on the outcome of behavior. This category includes various theoretical models such as Health Belief Model, Protection-Motivation Theory, Theory of Reasoned

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This editorial is based on Eversard, Vingerhoets, and Dekker (2006). Correspondence should be addressed to Joost Dekker, Ph.D., Editor-in-Chief, International Journal of Behavioral Medicine, Department of Rehabilitation Medicine, EMGO institute, VU University Medical Center, P.O. Box 7057, 1007 MB Amsterdam, The Netherlands. E-mail: j.dekker@vumc.nl
INTRODUCTION

Behavioral medicine first emerged in the 1970s as interest developed in the application of behavioral treatments, such as biofeedback and relaxation training, to alleviate physical health problems, and the role of learning in physical disease etiology. Later, behavioral medicine expanded to become defined as the interdisciplinary field concerned with the development and integration of social, behavioral, and biomedical science, the knowledge and techniques relevant to health and illness, and the application of this knowledge to prevention, diagnosis, treatment, and rehabilitation (Slater, Steptoe, Weikgrenant, & Dimsdale, 2003). Psychosomatics has a longer history and originated in the middle decades of the twentieth century as an application of psychodynamic psychotherapy to physical illness. Researchers and therapists in the psychosomatic tradition primarily focused on a small number of psychosomatic conditions such as hypertension (high blood pressure), peptic ulcer, rheumatoid arthritis, and bronchial asthma.

Behavioral and psychosomatic medicine were once polar opposites, the first concerned with behavior and the relevance of experimental psychological concepts such as operant conditioning to illness, and the second concentrating on intrapsychic and interpersonal influences. However, there has long been reconciliation such that the research described in behavioral medicine and psychosomatic conferences and journals is virtually interchangeable. The field has also moved beyond the small group of illnesses prioritized by psychosomatic medicine to a broader concept in which psychosocial and social factors are deemed to be relevant across the entire spectrum of physical illnesses. Modern research and practice views psychosocial factors as part of the broader biomedical and behavioral risk profile of disease, and operates to a variable extent in different cases, which depends on individual characteristics and on the disorder being investigated (Steptoe, 1998).

Other contributions to the Handbook have described many of the psychophysiological processes relevant to behavioral medicine and psychosomatics, including specific autonomic, neuroendocrine and immunological pathways, emotional influences on physiology and stress and illness. The purpose of this chapter is to outline how this psychophysiological knowledge is applied in behavioral medicine and psychosomatics and focuses on two broad issues. First is the application of psychophysiology to understanding the etiology of physical illnesses such as coronary heart disease, hypertension, infectious illness, immune-related diseases, and musculoskeletal disorders. This is the field in which psychophysiological methods have deepened our understanding of physical disease development and maintenance. The second general issue is the application of psychophysiology to the management of physical illnesses, and the evaluation of treatment effects. Additionally, I will explain how psychophysiology provides a powerful set of tools for research and clinical practice in behavioral medicine and psychosomatics. Researchers in this field have developed particular approaches to psychophysiology that differ to some extent from those that are commonly used in experimental research. The chapter, therefore, begins with a summary of methodological issues relevant to the application of psychophysiology to behavioral medicine and psychosomatics.

METHODS OF STUDYING PSYCHOPHYSIOLOGICAL PROCESSES

Much of nonpsychiatric clinical medicine involves the measurement of biological functions. As psychophysiology has expanded beyond traditional measures such as heart rate and electrodermal activity to include hormonal, immunological, and even molecular variables, the dividing line between where clinical measurement ends and psychophysiology begins has become increasingly opaque. It is, however, important to recognize that in behavioral medicine and psychosomatics, the psychophysiological measures studied fall into three categories (Steptoe, 2005):

1. Biological indicators of disease states, such as blood pressure in hypertension, blood glucose in diabetes, or
Summary of the 12th International Congress of Behavioral Medicine

in Budapest, August 29 – September 1, 2012

Budapest hosted the 12th International Congress of Behavioral Medicine (ICBM) this year, a conference that has been organized biennially since 1990. This prestigious scientific event was held in a beautiful environment, the Hilton Hotel in the Castle District, respectively the House of Hungarian Culture on August 29 - September 1, 2012. The theme of the 12th Congress Behavioral Medicine was “From Basic Science to Clinical Investigation and Public Health”. The local organizers of the international conference were the Hans Selye Hungarian Society of Behavioural Science and Behavioural Medicine (President: Dr. Adrienne Sauter) and the Institute of Behavioural Sciences at Semmelweis University (Director: Prof. Ferenc Túry) and co-workers of the Institute (Dr. Zolnai Cserháti, Dr. Mária Novák, Csilla Raduch, Dr. Jenő Lóránz, Noémi Somorjai, and Prof. Maria Kopp who passed away unexpectedly in April).

The ambitious program of the international scientific event attracted researchers from all over the world, altogether 50 countries were represented. The 850 presentations, including keynote and master lectures, symposia, paper sessions and posters centred around 26 topics in the field of behavioural medicine. It was a real challenge for the 730 participants to choose between presentations in the 8 parallel sessions, the only exception being the master lectures given by invited speakers, only two master lectures running parallelly.

Steep rise in research to discover policy/environmental solutions

Percent of nutrition, physical activity, and obesity abstracts at Society of Behavioral Medicine conference abstracts containing environmental or policy content. (Sallis et al., *Annals of Behavioral Medicine*, 2013)
RESPONSIBILITY
Starts with the
SOC

Responsibility

Problem
Solution
Responsibility
Responsibility

Do What's Right

Do the SOC
PHYSICIAN

HEAL thyself

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