ISSUE 21
VOLUME 13
Feb 2013

ISBM

International Society of Behavioral Medicine

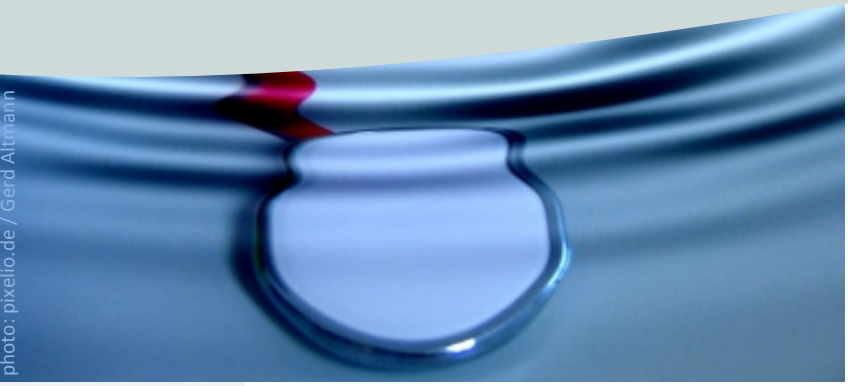


photo: pixelio.de / Gerd Altmann

Content

Publisher: ISBM - International Society of Behavioral Medicine
Editor: Beate Ditzen
Contributing Authors: Joost Dekker, Christina Lee, Paul Aveyard, Ronan O'Carroll, Carina Chan.
Layout: Andreas Wenger

Postal address:
ISBM – Communication Chair
Gutenbergstr. 18
D-35032 Marburg

News from the Editor

Dear ISBM members,

With this Spring-issue of our Society's newsletter, I send you warm greetings from cold and winterly Switzerland and at the same time wish you a successful and happy 2013!

Right in the beginning of this Newsletter-Issue in his letter, our President draws our attention to the next International Conference of the Society, ICBM, which will be held in Groningen, NL, in 2014. He emphasizes on international collaboration during the preparation of this conference and within the ISBM in general and, in line with this, much thought is dedicated to this topic in this current newsletter:

1. The news about our Society's Journal, IJBM, include a call for papers on dissemination and implementation of scientific results in Behavioral Medicine – a topic which relies heavily on international communication and cooperation.
2. During the preparation of the ICBM the local organizing team in Groningen, NL, will be working hand-in-hand with the program chair from Scotland, Ronan O'Carroll, former president of the UK Society of Behavioural Medicine (UKSBM).
3. This can be seen as another sign of collaboration and in this Newsletter issue these international contacts lead us to the portrait of UKSBM (see p.6) and to the interview with Ronan O'Carroll (p. 8).
4. In the UKSBM portrait, Paul Aveyard, president of the UKSBM explicitly invites our international ISBM members to the yearly conferences in Britain and in the interview Ronan describes how his career has been shaped by international contacts and collaboration.
5. So, in line with this overall theme, and in a collaborative effort both between societies and nations, there will be an ISBM Board meeting and an INSPIRE network meeting, both planned at the upcoming SBM-Conference in San Francisco, USA, this Spring (see INSPIRE and News from the Member Societies).

To summarize and in terms of collaboration we are facing a busy year and I, personally, look forward to be in contact with many of you from around the world.

Beate Ditzen
Newsletter Editor

ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine

Letter from the president

Dear all,

ISBM is a network organization. The members of ISBM are independent organizations, which share a common interest in behavioral medicine. ISBM member societies function independently, pursuing scientific or professional goals in the field of behavioral medicine. ISBM aims to encourage and coordinate communication and interaction among member societies, scientists and professionals in the field of behavioral medicine. Another major aim of ISBM is to maintain liaison with related scientific and professional organizations.

How can ISBM do this? We have our very successful ICBM conference, which is a major platform for exchange of information and for building scientific and professional liaisons. These conferences have been very successful. At the same time, I believe that we can further develop our conference. I have contacted organizations in the field and proposed to nominate a (co-)chair of one of the ICBM congress tracks. All organizations have accepted to do this. The Scientific Program Committee now needs to approve the following nominations.

- The International Commission on Occupational Health (ICOH) nominated the chair of the track Work-related health.
- The American Psychological Association – Division 38 Health Psychology (APA Div 38 Health Psychology) nominated the co-chair of the track Cancer.
- The International Network for Brief Interventions for Alcohol and other Drugs (INEBRIA) nominated the co-chair of the track Addictive Behavior.
- The European League Against Rheumatism, Standing Committee of Health Professionals in Rheumatology (EULAR HP) nominated the co-chair of the track Pain, musculoskeletal and neurological disorders.
- I expect that European Society for Cardiology (ESC) will soon nominate the co-chair of the track Cardiovascular disease.

I expect that collaboration in the context of ICBM will facilitate communication and interaction with members of these organizations. I expect that the quality of our conference will be further enhanced by strong collaboration with these scientific organizations. Furthermore, I hope that collaboration in the context of ICBM will be the starting point for other modes of collaboration with these organizations (e.g. on guidelines).

I want to encourage all our members, both societies and individual members, to use ICBM 2014 in Groningen, the Netherlands to further develop international collaboration. In my contacts with member societies, I have noticed a strong need for international collaboration. I have noticed that colleagues tend to be pleased with an invitation for a talk on potential collaboration. This can be at the level of a joint symposium, at the level of a visit, at the level of a common publication or project, at the level of a regional network, at the level of a joint conference, or still another level.

Best wishes to all of you,

Joost Dekker
President of ISBM

ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine

Board Members 2012-2014

Joost Dekker
President, 2012-2014
VU University Medical Center, The Netherlands
j.dekker@vumc.nl

Norito Kawakami
Past President
University of Tokyo, Japan
norito@m.u-tokyo.ac.jp

Adrienne Stauder
President Elect
Semmelweis University Budapest, Hungary
staadr@net.sote.hu

Petra Lindfors
Treasurer
Stockholm University, Sweden
pls@psychology.su.se

Frank J. Penedo
Secretary
University of Miami, FL, USA
fpenedo@miami.edu

Anne H. Berman
Education and Training Committee
Karolinska Institutete, Sweden
anne.h.berman@ki.se

Urs M. Nater
Communications Committee
University of Marburg, Germany
nater@uni-marburg.de

Shin Fukudo
Finance Committee
Tohoku University, Japan
sfukudo@med.tohoku.ac.jp

Paula Repetto
International Collaborative Studies Committee
Catholic University of Chile
prepetto@uc.cl

Christina Lee
International Journal of Behavioral Medicine
University of Queensland, Australia
c.lee@psy.uq.edu.au

Yuji Sakano
Membership Committee
Health Sciences University of Hokkaido, Japan
sakano@hoku-iryo-u.ac.jp

Kasisomayajula Vishwanath
Organizational Liaison Committee
Harvard School of Public Health, USA
Vish_Viswanath@dfci.harvard.edu

Ronan O´Carroll
ICBM Scientific Program Committee
University of Stirling, GB
ronan.ocarroll@stir.ac.uk

Neil Schneiderman
Strategic Planning Committee
University of Miami, FL, USA
nschneid@miami.edu

Beate Ditzen
Newsletter Editor
University of Zurich, Switzerland
b.ditzen@psychologie.uzh.ch

Carina Chan
INSPIRE
Monash University, Australia
carina.chan@med.monash.edu.my

ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine

News from the Editor-in-Chief of IJBM

The International Journal of Behavioral Medicine is going from strength to strength. As I reported in the previous newsletter, our Impact Factor has jumped to 2.625. Partly as a result of this, the editorial team is coping with substantial growth in both number and quality of submissions, as well as some very interesting opportunities for special issues and special publications.

Submission numbers in 2012 were the highest ever, with a total of 217 submissions in the year (compared with 185 in 2011, and 142 in 2010). And it looks as if 2013 will be even bigger. This is an excellent outcome for the Journal and the Society, suggesting that our reach and influence is steadily increasing. An unwanted consequence of more, and higher quality, submissions is a growing backlog of papers that have been accepted but not yet published. Accepted papers are available on OnlineFirst within a couple of weeks of acceptance, but the wait for hard-copy publication is continuing to grow.

Following discussion with Janice Stern, our Senior Editor at Springer, in mid 2012 we increased page length per issue from 100 to 160, but this is not sufficient. Therefore, we will switch to 6 issues per year from 2014. This should enable us to continue to accept papers that are methodologically sound, well written, compelling, and original, from around the world, while reducing the wait for hard-copy publication to no more than 6 months.

It also gives us room to continue our tradition of exciting and high-quality Special Issues and Special Series. We have several of these in process at the moment. A series on **Functional Somatic Syndromes**, guest edited by Professor Urs Nater, is almost ready for publication and will appear in the second issue for 2013. A special issue on **Behavioral Medicine in China**, guest edited by Joost Dekker, Bo Bai, Brian Oldenburg, Chengxuan Qiu, and Xuefeng Zhong, and another on **Research to Reality: The Science of Dissemination and Implementation in Behavioral Medicine**, guest edited by Carina Chan, Brian Oldenburg, and Vish Viswanath, are both currently open for submissions. And of course we continue to welcome submissions on any aspect of behavioral medicine, at any time.

Editor's Choice

The European Guidelines on Cardiovascular Disease Prevention in Clinical Practice were published in Issue 4 2012, jointly with the European Heart Journal. This comprehensive and widely relevant document was developed by a large team of experts from across Europe, including a number of senior members of the International Society for Behavioral Medicine. It has leapt to the top of our "most downloaded" list with a remarkable total of 1,237 downloads. You can see our most downloaded articles and get them for free at http://www.springer.com/medicine/journal/12529 - just click on 'Most Downloaded Articles' and follow the links.

Christina Lee
Editor IJBM

ISSUE 21 VOLUME 13 Feb 2013
ISBM International Society of Behavioral Medicine

Call for Papers

Research to Reality: The Science of Dissemination and Implementation in Behavioral Medicine

Public health programs are only effective if they are widely disseminated and implemented. The different values and perspectives of practitioners, program implementers, policy makers and researchers may be a significant barrier to this. Practitioners often find generic evidence-based interventions difficult to implement in community settings, especially when there is limited information about how to adapt programs to the local context. Furthermore, public health decision makers and program implementers are often reluctant to consider new interventions when effectiveness has not been demonstrated in their particular setting or country. In contrast, researchers place greater emphasis on internal validity than on generalizability and external validity.

"Dissemination" refers to the flow of evidence-based but customised information or intervention to well-defined target audiences. "Implementation" refers to the adoption and integration of evidence-based health interventions into specific settings. "Translation" refers to applying or adapting research findings or evidence to different community or population settings. Effective dissemination, implementation and translation of public health and behavioral medicine interventions require the triangulation of evidence from formal trials with case studies, expert opinion, network analysis, and systems thinking, as well as assessment of the local context. As a follow-up to a highly successful satellite forum on dissemination and implementation at the 11th International Congress of Behavioral Medicine, Budapest, August 2012, the *International Journal of Behavioral Medicine* is issuing an ***international call for papers*** to address issues pertaining to dissemination, implementation and translation in behavioral medicine. Submissions are due June 1, 2013.

Research Questions: We are particularly interested in papers that address, but are not limited to, these topics:

- What theoretical models and approaches are relevant to understanding and improving dissemination, implementation and translation in Behavioral Medicine? What evidence demonstrates the effectiveness of these models and approaches?
- What methods and strategies are being used in dissemination and implementation studies in behavioral medicine?
- How can we maximize the impact of behavioral medicine evidence on public health policy and practice?

We will consider papers that report original research, conceptual or theoretical papers, meta-analyses, systematic reviews, and papers that highlight innovative methodologies. Papers from studies conducted in both developed and developing countries are welcome.

Instructions: Please submit your manuscript by June 1, 2013 following the standard requirements for *IJBM* articles and are subject to standard editorial and peer review See http://www.springer.com/medicine/journal/12529
Please address any questions regarding this special issue to the Guest Editors:

Dr. Carina Chan: carina.chan@monash.edu
Dr. Brian Oldenburg: brian.oldenburg@monash.edu
Dr. Vish Viswanath: vish_viswanath@dfci.harvard.edu

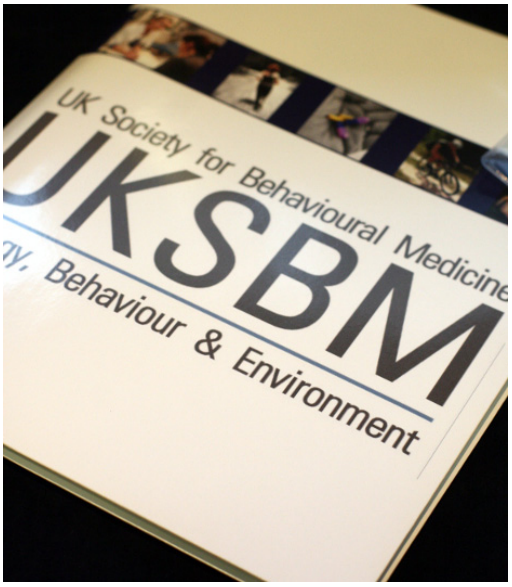
ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine

The development of the UK Society of Behavioral Medicine

Biology, Behaviour, and Environment

The UKSBM began life under a decade ago and is growing in numbers and influence. The main focus of the Society is our annual scientific meeting, which tours the country each year. Originally, a one-day meeting, the meeting has grown to a very packed two-day event. The conference is enormously popular with its delegates, which give rave reviews of the content, but sometimes wish for time to sit down and for less packed days. It seems likely that the three-day conference is on the horizon for the Society.

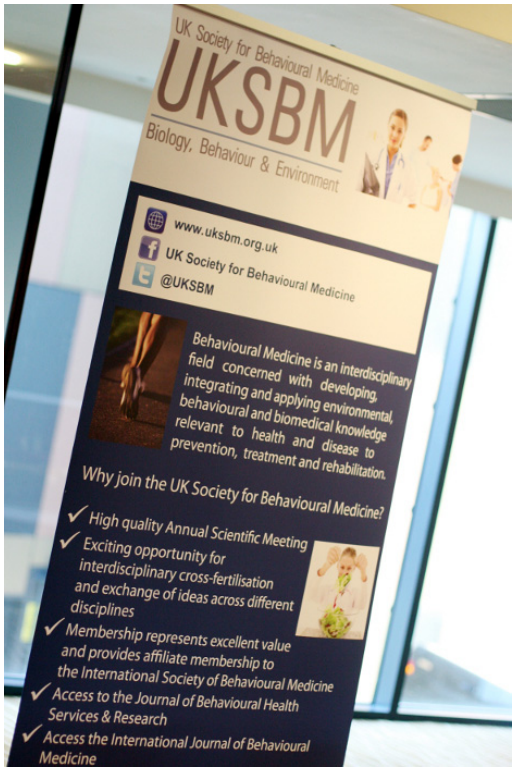
The conference itself attracts over 250 delegates, which is more than the number of members. We plan changes to try to ensure that we attract and engage scientists interested enough in our society to come to the meetings and engage them in membership and the broader work of the Society. We have a growing membership and the Society has used its members to respond to consultations on government policies, or guidelines issued by the National Institute for Clinical Excellence, for example.



The Society has also lobbied for a chief social scientist to sit alongside the other chief scientific advisors to the Government and it seems possible that this post may indeed be created.

The success of the conference and the growth in the membership has meant we have a growing bank balance, but harassed officers. Our committee are all volunteers and keeping track of the membership, updating the website, our Twitter accounts, our Facebook page, and organising responses to consultations is all done on top of busy day jobs. Our need for volunteer committee members will continue, but we are looking to support those members, perhaps by employing someone who can lead the Society's response to consultations and get and collate views and evidence from our members in ways that do not require them too much extra work.

ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine



The challenge of success is that the system that has supported the Society so well up to now may need to change to support the continued growth of our Society.

One key priority for the Society is to grow a future generation of UKSBM researchers. To that end, we have a thriving early career network. For the past few years the early career network has met to discuss topics of interest. At the last conference, we had journal editors create a panel and the network submitted questions on how to get published. It was consoling to hear that even experienced researchers and editors find it just as hard to get published sometimes as the rest of us. The network is organising training events during the year to create a sense of unity for researchers and to support each other in their work.

The strength of the Society is its multidisciplinarity, which is something to which the Society is strongly committed. We have scientists from a wide range of backgrounds, reflecting the emphasis on biology, behaviour, and environment, which is the strapline of our Society. The range of disciplines engaged with our Society is large, and our task for the future is to reach out to and engage more readily with professions who use behavioural medicine in their daily lives, but are unaware of the scientific basis of their work and the society that supports and promotes that. We have had outreach events at academic conferences aimed at clinician researchers and we continue to use informal networking opportunities to reach out to influence clinical practice, social policy, and research in these areas. We are looking forward to exciting times ahead and would welcome members of others in the ISBM family to our conference.

Paul Aveyard
President of UKSBM

ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine

Interview with Ronan O'Carroll

Q1. When we look at your background, from the beginning the combination of biology and psychology becomes evident. Can you tell us about your mentors and about which situations have shaped your research interests?

A1. I went to University in Edinburgh in 1975 to study Biology because; (a) I wanted to avoid getting a job and (b) Biology was one of the few subjects I was interested in at school. Initially I found studying biochemistry, zoology and physiology pretty difficult and looked for a "soft" option to complete my courses, and chose psychology as I assumed it would be about sex and dreams. I enjoyed it and became interested in Clinical Psychology. In the late 1970's, in the final (4th) year as an undergraduate studying Psychology, students sometimes had 1:1 tutorials with staff. I was lucky enough to have a series of 1:1 tutorials with Ralph McGuire (who ran the Clinical Psychology training programme in Edinburgh for many years) and he really inspired me to become a Clinical Psychologist. Later in life, in 1990 Ralph encouraged me to join him doing some clinical sessions in general medicine, in the Dept. of Psychological Medicine in Edinburgh Royal Infirmary. I accepted his invitation and am still doing these every Tuesday afternoon, 23 years later.

In 1980 the competition to obtain a place on a Clinical Psychology programme was (and still is) very high in the UK, so I decided to try and do a PhD in order to increase my chances of getting a place on a Clinical Psychology training scheme. I applied for a PhD studentship in the MRC Brain Metabolism Unit in Edinburgh, entitled "The behavioural effects of androgens in men" under the supervision of John Bancroft. He later became Director of the Kinsey Institute in the US and was a brilliant supervisor and taught me the importance of rigorous scientific methodology. We conducted a number of placebo-controlled studies investigating the effects of testosterone on mood, sexuality and aggression in men. This was my first exposure to behavioural medicine and I became hooked. I was fortunate enough to be awarded the Kinsey Institute international PhD dissertation prize in 1984. This came with a $1,000 prize, which I recall was particularly welcome at the time, as my wife and I desperately needed to buy a bath to replace a shower as we had just had our first baby.

The next major influential figures were Marie and Derek Johnston. I had begun to carry out more research in the area of psychology in a general medical setting and I joined them at the University of St Andrews in 1999. They really introduced me to Health Psychology and pointed out that a lot of my work had been in the domain of Health Psychology, I just hadn't been aware of it! I learned a lot from both of them, and continue to do so. Marie in particular emphasised the limitations of cross-sectional designs relying on self-reports, and the need for intervention studies and the importance of measuring actual behavior. She encouraged me to join ISBM and attend ICBM meetings as she felt I would find both rewarding. Annoyingly, as usual she was correct. So the main influences on my career to date have been a clinical psychologist, a psychiatrist and two health psychologists.

ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine

Q2. How did you move from your early research on androgens to your current research interests?

A2. I am afraid I am a really bad example as to how to plan a career, as I have never had a well thought out plan. Rather, I have drifted into research areas that have caught my attention at the time. This has often been the result of clinicians approaching me with questions such as "Why do people not attend accident and emergency as soon as possible after a heart attack?" or "Are people likely to suffer significant cognitive impairment following resuscitation after a cardiac arrest?" I didn't know the answers to these types of questions, but set up research projects to try and answer them. More recently, my Dad suffered a mild stroke and I noticed that his adherence to his secondary preventative medication was poor. This stimulated me to start a research programme on medication adherence. So far, I have been very fortunate in that everywhere I have worked I have had the freedom and flexibility to move into new behavioural medicine research areas quite easily.

Q3. Where there important turning points in your career, which have influenced or changed your work philosophy?

A3. I think a real turning point was doing my PhD with John Bancroft. At that time I was simply planning to use a PhD as a qualification to increase my chances of obtaining a training place as a Clinical Psychologist. My intention was to then spend the rest of my career as a practicing Clinical Psychologist working in adult mental health in the UK National Health Service. However, I really enjoyed the behavioural medicine research process in my PhD. After working as a full-time Clinical Psychologist for a couple of years, I realised I wanted to return to research and that an academic post suited me better. I particularly enjoy the variety of research, teaching, supervision and some clinical work.

Q4. Where do you see your research going over the next 5 to 10 years? What would you like to accomplish?

A4. I have become more interested in the role that emotions play in guiding our health related behaviours, i.e. the role that "feelings" rather than "facts" play, and am keen to conduct evaluations of large scale projects that try and take emotions into account when trying to change behavior. For example, we are currently running a large trial aimed at increasing the uptake of colorectal cancer screening in Scotland. In Scotland every 2 years all people over the age of 50 years are posted a test-kit to return a stool sample by post for the detection of traces of blood in the sample. This programme is very effective in the early detection of colorectal cancer and saves many lives. Unfortunately the test-kit return rates are low, particularly from men and people living in areas of social deprivation. We are investigating the role that emotions such as disgust play in the decision not to return a test kit.

At the UKSBM-Meeting, Stirling, 2011

I am also interested in why 90% of the UK general population say they support the idea of organ donation, yet only 31% have signed on the UK organ donor register. My team are investigating emotional barriers to organ donor registration and evaluating whether these barriers can be overcome.

I also plan doing more work in the area of increasing adherence to medication in long term conditions. Our work to date has focused on two main themes (a) tackling non-intentional non-adherence by trying to make medication-taking become an automatic habit, thus removing the load on prospective memory and (b) tackling intentional non-adherence by eliciting patient's beliefs about their medicines to see if any erroneous beliefs can be modified. I find Leventhal's common-sense self-regulatory model very helpful in informing this work, i.e. that each person has a set of mental representations that they hold about their illness and its treatment (cause, timeline, controllability etc.). With stroke patients we found that many people have a lot of concerns about their medication that leads them to decide not to take them (e.g. they believe they have been prescribed too many tablets, that this is not "natural", may be harmful etc.). Many of these patients have never discussed these concerns with their doctor, who may be completely unaware that the patients have these beliefs and are not taking their tablets as a result.

I am very glad that I have continued to see patients and do a clinical session in a general hospital every week and I plan to continue doing so. I find this really helps provide grounding and reality-testing for our "ivory tower" theories from academic research. For example, following Leventhal's self-regulatory model, I am impressed how useful it is to routinely ask patients who are referred to me what they think about their condition and its treatment (i.e. eliciting their idiosyncratic illness and treatment beliefs). Repeatedly it emerges that they hold views that differ markedly from their clinicians, and this can help explain why they may not be adhering or coping well with their condition.

Q5. In which direction would you like the field of behavioral medicine research and clinic in general to develop over the coming years? Where do you see the challenges in our field?

A5. I think we really need to demonstrate that behavioural medicine research can lead to lasting health behavior change at a population level. It is becoming increasingly accepted that behavior is key to many preventable conditions via smoking, obesity, sedentary behavior, diet and alcohol. Our challenge is to demonstrate to policy makers that we can make a significant and lasting change to health behaviours that leads to improved health outcomes.

Q6. For the worldwide readership of the ISBM Newsletter, impressions of the country and of the specific research environment of the interviewees are of particular interest. Do you see any specific and important points about doing behavioral medicine research in Scotland, UK?

A6. Scotland's health is pretty poor. For example, in the Calton area of Glasgow the life expectancy for a man is 54 years and that is a disgrace. As a nation we tend to lead unhealthy lifestyles. In a recent survey the 5 behaviours (smoking, drinking too much alcohol, poor diet, physical inactivity and obesity) that commonly lead to ill health were assessed in a

ISSUE 21 VOLUME 13 Feb 2013
ISBM International Society of Behavioral Medicine

community survey of Scottish adults. 97% of Scottish adults endorsed at least one of these, 55% had 3 or more and 20% had 4 or 5. However, the Scottish Government recognizes that health behavior change is key and are supportive of behavioural medicine research in this area. One advantage of working in a relatively small country is that it is relatively easy to get to know like-minded researchers and establish collaborative multidisciplinary research relationships. I also think that Scotland does some things really well e.g. introducing a public smoking ban, and of course, Scots invented and developed so many things that make the world a better place e.g. beta blockers, penicillin, chloroform, television, the telephone etc. To quote Winston Churchill: "*Of all the small nations of this earth, perhaps only the ancient Greeks surpass the Scots in their contribution to mankind*". Personally, I think the ancient Greeks were pretty good, but I'm not sure they surpass the Scots.

Q7. You are extremely productive in your career and it is hard to imagine that you have any time left outside your lab. What do you like to do for fun?

A7. I don't agree that I am particularly productive, and I am sure my employers would like me to do more! However, I firmly believe that one should try and have a healthy work/life balance. I certainly don't work all the time and believe that having a laugh on a regular basis is crucial. I very much enjoy playing and watching sport. I hold a firmly held conviction/delusion that I was quite a good soccer player, and I still play, though my playing style now is largely that of an immobile, complaining striker. I enjoy tennis and squash but tennis elbow is limiting that of late. Our 3 children have now grown up and left home (no psychologists among them) and we have replaced them with 2 black Labrador brothers, Paddy and Finn and they are great fun (now that Finn has stopped destroying our house) and they keep us busy. I find walking the dogs a very good way to unwind. I also like socializing, watching movies and travelling.

Q8. And, finally, again for our international readership: If you had to leave Scotland and move to a different country; where would you like to live (and perhaps to do research)?

A8. We did move to Canada and lived there for 2.5 years in the late 1980's. I really enjoyed our time there and it was great to experience life in a different country. I worked at Memorial University in St John's and helped run their Clinical Psychology programme. Since then I have occasionally considered working abroad (particularly during Scottish winters), but for family and work reasons we have remained in Scotland and I don't have any regrets. I like the Scottish sense of humour, and I think we evolved this to cope with our weather.

Thank you very much for your time!
Beate Ditzen

Ronan and Phineas Gage

ISSUE 21
VOLUME 13
Feb 2013
ISBM International Society of Behavioral Medicine

INSPIRE's update

To kick start 2013's plan to engage more early career researchers, INSPIRE will be present at the upcoming annual meeting of the Society of Behavioral Medicine in San Francisco. We will introduce INSPIRE at the special interest group meeting as well as the students meet-and-greet. We look forward to meeting and recruiting interested members from North America.

As an ongoing development and planning for INSPIRE, we would like to make a call to all student and early career researchers to join INSPIRE. If you are within 5 years from your most recent graduation, please do join the INSPIRE community. Visit our new website (http://isbminspire.com/) and keep up with what is happening! INSPIRE is a network created for you so please let us know how we can better support your research and career development in the field of behavioural medicine!

I would also like to draw your attention to an international call for papers for a special issue in the International Journal of Behavioral Medicine, "**Research to Reality: The Science of Dissemination and Implementation in Behavioral Medicine"**. Early career researchers are strongly encouraged to submit papers to this special issue should your work is related to dissemination and implementation research. Close for submission is 1 June 2013. Please see attached Call for Papers on page 5.

Wish you all the best in 2013.

Carina Chan, PhD
INSPIRE Chair
carina.chan@monash.edu

News from the Societies

Event	**71st Annual Scientific Meeting of the American Psychosomatic Society (APS)**
Date	March 13 – 16, 2013
Place	Miami Florida (USA)
Organizer	American Psychosomatic Society
Contact / Info	http://www.psychosomatic.org/AnMeeting/current.cfm

Event	**34th Annual Meeting of the Society of Behavioral Medicine (SBM)**
Date	March 20 – 23, 2013
Place	San Francisco (USA)
Organizer	Society of Behavioral Medicine
Contact / Info	http://www.sbm.org/meetings/2013

Event	**14th Congress of the German Society for Behavioral Medicine (DGVM)**
Date	September 26 – 28, 2013
Place	Prien am Chiemsee (Germany)
Organizer	Deutsche Gesellschaft für Verhaltensmedizin und Verhaltensmodifikation (DGVM)
Contact / Info	http://www.dgvm-kongress-2013.de/cms/home

Event	**9th Annual Scientific Meeting of the UK Society for Behavioral Medicine (UKSBM)**
Date	December 9 – 10, 2013
Place	Oxford (UK)
Organizer	The UK Society for Behavioral Medicine (UKSBM)
Contact / Info	http://uksbm.org.uk/?page_id=2288