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Behavioral Medicine in the 21st Century: Transforming “the Road Less Traveled” into the “American Way of Life”

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Abstract

A key objective of this paper is to describe some major challenges and opportunities facing the behavioral medicine field in the current decade. Amidst current U.S. statistics that present a sobering image of the nation’s health, there have been a number of notable achievements in the behavioral medicine field that span the scientific/health continuum. Yet, many of these achievements have received little notice by the public and decision makers. A case is presented for the potential of scientific narrative for presenting behavioral medicine evidence in ways that engage attention and compel action. Additional areas for behavioral medicine engagement include expanding interdisciplinary connections into new arenas, continuing the growth of activities involving emerging technologies, building international connections, and engaging with policy. Finally, the fundamental importance of an integrated behavioral medicine field that plays an active role in supporting and advancing its members and the field as a whole is discussed.

Keywords

Behavioral Medicine; Narrative; Future directions; Challenges and opportunities

“If I look at the mass I will never act; if I look at the one, I will”. Mother Theresa

Introduction

Over the last century, the demographic principles supporting individual achievement and accomplishments, creative pursuits, and related successes have made the “American way of life” a source of national pride. Indeed, such achievements have led many Americans to assume that the U.S. is a world leader in most facets of life, including health and wellbeing. Discouragingly, the reality of the nation’s circumstances surrounding health tells a story that is quite different from the public’s general perceptions (1). Among the sobering statistics are the fact that the U.S. has been ranked a surprising 28th for life expectancy at birth (behind virtually all other wealthy nations) (2), yet we are ranked among the top countries in the world in health care spending and costs; ~75% of all health care dollars are spent on patients with preventable disease (3); each day almost 4,000 children smoke their first cigarette, with more than 26% going on to become daily smokers (4); American adults ages 50 and over

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have among the highest levels of functional disability among developed nations (2); and the percentage of U.S. obese adults eclipses that of any other developed country (2).

But do such sobering statistics have to be our collective destiny? There is in fact a “less traveled” path to health built on behavioral medicine knowledge and scientific successes. These successes include a halving of U.S. tobacco use in less than 50 years (5); demonstration of the clear potency and cost-effectiveness of a lifestyle approach, relative to medications and usual care, in the prevention of type 2 diabetes (6); success of behavioral prevention efforts in halving the incidence of HIV/AIDS over the past 15 years (7); advances in understanding gene by behavior interactions (e.g., the impact of life stress on the incidence of depression is moderated by genetic factors (8); and development of successful behavioral approaches for depression and anxiety, as well as key health-related behaviors such as smoking cessation and physical activity (9).

As reflected in these successes, the behavioral medicine field encompasses a substantial and growing evidence base spanning a range of health and policy arenas. Among such health areas are tobacco control, pain relief, behavioral approaches to HIV prevention, alcohol and substance use, physical activity promotion, weight control, eating disorders, behavioral informatics, multiple health behavior change, interdisciplinary perspectives on health and chronic disease prevention and control, and childhood obesity prevention policies and approaches. Yet, relatively few Americans appear to understand or appreciate what “behavioral medicine” is or how it can positively impact people’s lives. Arguably, then, a major challenge for the field concerns not only continuing to build out the scientific evidence base, but also making policy makers and the public alike more fully aware of the plethora of behavioral medicine evidence already available. One approach for doing so involves increasing the field’s impact through sharing our evidence in ways that compel action at the individual, organizational, and societal levels. In essence, we need to seek out more powerful ways of telling our evidence-based “stories”.

The Power of Narrative

The application of narratives (i.e., stories) is a daily occurrence in the lives of most Americans. Such “story-telling” is used frequently to impact a diverse range of behaviors, from product purchase to civic engagement. Such observations beg the question as to whether behavioral medicine scientists can find better ways to engage the public to increase the odds that our scientific evidence will be more carefully attended to and acted upon.

The challenge of communicating evidence in compelling ways is one facing the scientific field more generally. For example, as noted in a recent commentary published in a major medical journal, “Facts and figures are essential, but insufficient, to translate the data and promote acceptance of evidence-based practices and policies” (10) (p. 2022). Is there an appropriate way to harness the power of narrative communication while maintaining the integrity and objectivity that is at the heart of the scientific enterprise?

Communication experts define narrative communication as the telling of a cohesive and coherent story that has a beginning, middle, and end, provides information about characters, scene, and conflict, and which provides some resolution (though not necessarily a “happy ending”) (11). Such narrative stories may be effective in motivating responses (useful, positive reactions), at least in part, through the process of homophily—the tendency of individuals to associate and bond with similar others (12). For example, in a study of 710 users of an online fitness program, researchers systematically manipulated homophily level by randomly clustering on-line users into groups based on either specific personal characteristics (e.g., obesity) or not (12). The process of encouraging the adoption of a healthy behavior (in this case, use of an Internet-based diet diary) was initiated by having a

confederate in each of the 10 user groups model the target health behavior. Across the 7-week study period, the homophilous social networks demonstrated more than a three-fold adoption rate of the target behavior than the non-homophilous groups. The behavioral advantage associated with being in a homophilous group was particularly pronounced for obese individuals; when randomly assigned to a non-homophilous group, no obese individual adopted the Internet-based diet diary. These results suggest that the obese individuals under study may have been more dependent upon the configuration of the social network for making such health-related decisions relative to non-obese individuals.

A second reason why narrative communication may promote change may relate to the types of personal schemas (views, viewpoints, perspectives) that each of us uses in making sense of our world (Andy Goodman, Goodman Institute, personal communication, October 2011). Such perspectives often include both emotional and analytic perceptions of events around us (11). Information directed at only one portion of our schema (i.e., the analytic part) may be comparatively less powerful in changing our views about events that happen in our lives (13–15).

A third proposal advanced to explain why evidence alone may not inspire action concerns what has been described as “the identifiable victim effect” often lost in aggregated data (16). In experiments conducted by Paul Slovic and colleagues (2007), after completing a short survey on technology for which they received a small monetary incentive, students received either fact-based monetary appeals from Save the Children versus appeals describing an actual person experiencing the calamity in question. Those reading the more personalized story about an individual victim donated more than twice as much of the incentive money compared with those reading the fact-based appeal. In fact, Slovic and others have argued that hearing about the scope of a problem through facts and statistics may make the problem seem overwhelming and unsolvable, leading to a “drop in the bucket” effect that may discourage action (16). Strikingly, when the researchers compared a personalized story combined with statistics concerning the problem in question versus the personalized story alone, students donated on average more money in the personalized story alone condition. This suggests that the “drop in the bucket” effect of aggregated statistics may overwhelm the persuasive impacts of a personal story, at least in situations where the statistics are largely negative (e.g., numbers of people dying from breast cancer, as opposed to the number of people that have been helped by a particular treatment). In contrast, some researchers have suggested that combining the two forms of communication may be more effective than either communication type alone (17).

As part of the evidence base showing the strength of narrative communication, Hamill, Nisbett et al. (1980) showed that providing a compelling story, even when it is accompanied by information emphasizing that it is inaccurate, can have a significantly greater impact on people’s perceptions than the data accompanying it (18). These studies underscore human susceptibility to sample bias—a putative driver of prejudice. A well-known example of such sample bias is reflected in the national crusade by actress Jenny McCarthy, who has campaigned against childhood vaccinations, claiming that they caused autism in her son (19). It has become eminently clear that such personal health stories, told in provocative ways, can “hijack” public discourse and dilute the impact of an entire field of evidence (20), with serious public health ramifications (21).

Additional arguments that have been discussed in support of narrative communication as a potentially useful health behavior change tool include suggestions that its more engaging and less overtly directive format may reduce the likelihood of an audience summarily dismissing a health message. Similarly, its ability to grab and hold people’s attention may help it compete better in the health information “marketplace” (11).

On the other side of the issue, the scientific community is becoming increasingly aware of the dangers of presenting data in ways that reduce public understanding and do not compel action. Arguably among the most profound examples of this failure to adequately communicate scientific data in a clear and compelling way was the scientific communications leading up to the Space Shuttle Challenger Disaster on January 28, 1986. In subsequent evaluations of the events occurring around the disaster, it has been suggested that while the scientists involved had indeed reached the correct conclusion concerning the vulnerability of O-ring damage at low launch temperatures—the major cause underlying the space shuttle explosion—the dangers implicit in the available data were not communicated to decision-makers in a way that compelled clear action (22).

Building the Evidence Base for Scientific Narrative

While the systematic study of narrative remains in its infancy in the scientific arena, the studies that are available are promising. For example, Houston et al. (23) have reported that culturally relevant storytelling may improve blood pressure control in patients with hypertension. In an inner-city “safety net” clinic in a southern city, 299 African-American patients with hypertension (ages 18–80 years) were randomized to receive either three interactive DVDs containing stories from fellow patients or a more standard informational DVD. In those patients with initially uncontrolled hypertension ($n = 123$), those randomized to the culturally relevant story-telling arm had significant improvements in systolic and diastolic blood pressure at 3 months and in systolic blood pressure at 6 to 9 months relative to the standard DVD arm.

Those in the field have been quick to point out the caveats of scientific storytelling. These include the observations that stories do not substitute for evidence, but are simply a way of expressing it; stories need to reflect the realities and complexities of the health issues we study, including the challenges involved; depending upon the audience and circumstances involved, storytelling might not be a suitable way of communicating information (i.e., there is a “time and place” for stories); and stories need to represent the evidence fairly and honestly (i.e., with balance while minimizing personal bias).

With such caveats in mind, there are basic steps that researchers can take to begin to harness the power of stories to engage and compel action, including the following:

Put a “human face” on the problem—Making health information “come alive” through humanizing the problem can be a powerful way to capture the attention of those we are trying to reach. A “human face” may be particularly important for critical health challenges such as the growing U.S. health inequality gap and the increased proportion of racial/ethnic minority groups projected in the aging U.S. population (2, 24). Driven largely by socioeconomic circumstances, two examples of this gap are the substantial Black-White differences in mortality, and the large geographic inequalities in health outcomes in the U.S. The traditional scientific approach to conveying such issues to policy-makers and the public is through graphs and charts summarizing, for example, racial disparities in U.S. breast cancer mortality rates (25). An alternative approach is to accompany such evidence with a compelling story that can make the dramatic toll that such disparities can have on a group palpable. Dr. Otis Brawley, a physician working at Grady Memorial Hospital in Atlanta, GA, has done just that in his book *How We Do Harm: A Doctor Breaks Ranks About Being Sick in America* (26). An excerpted story from the book captures the complex issues involved in not getting care early enough to make a difference: “... Edna felt the lump in her breast 9 years ago. Her employer wouldn’t let her take just two or three hours of sick leave to go to the doctor.... She also feared the health care “system”. Would the doctors scold her? “Experiment” on her? Deny her care? Her fear is palpable.... We try three treatments and

manage to contain her disease for a while. *She dies at age 55, about 20 months after walking into the ER.*”

Have Participants Tell their Own Personal Intervention-based “Success”

Stories—Most researchers have a wealth of stories from study participants that can provide the types of firsthand information to which decision-makers and the public alike can relate. Yet, such stories rarely come to the foreground when successful interventions are being described. In addition to supplying the rich detail typically lacking in scientific reports of interventions, participants’ personal stories can help with intervention dissemination efforts. Among the types of venues in which participants’ personal stories can be shared are program-relevant websites, scientific blogs, and press releases and news stories. Use of participants’ personal stories could be incorporated as part of the mixed methods approach supported by current “best practice” perspectives in the field (27).

Harness the power of communication media to capture attention and compel action

New and innovative forms of communication media have the potential for seizing the public’s imagination in ways that the most thorough of scientific reports often cannot. A case in point can be found in the physical activity arena. One of the three key health behaviors linked with the major chronic diseases responsible for approximately 50 percent of global mortality (28), physical inactivity accounts for more than \$76.6 billion in annual U.S. health expenditures (29). Yet, the majority of Americans do not meet national physical activity recommendations (30).

While over the past three decades several Federal and national organizations have developed recommendations for physical activity and health (31, 32), the first U.S. Department of Health and Human Services’ (DHHS) Physical Activity Guidelines were released in 2008 (30). The Guidelines, which took two years to complete, are captured in a U.S. DHHS report of about 500 pages in length. The report represents the work of 11 expert subcommittees that undertook an exhaustive evidence review and deliberations around nine major health outcomes in addition to several targeted subgroups (e.g., youth, underserved populations) (30). While a significant amount of work went into developing the Guidelines, the actual proportion of scientists, health professionals, policy makers, and the public that are aware of it or actually use it remain unclear. Anticipating that the massive size and scope of the report would make it difficult for professionals to use, a more engaging “at-a-glance” fact sheet was developed for professionals (33). Providing a quick reference for busy professionals, the fact sheet represents a more accessible format for communicating important health information in the physical activity arena.

Such fact sheets represent a positive step in communicating scientific evidence in a more approachable way. Yet, arguably, neither the original report or fact sheet has received the type of public attention that has been generated by a simple 9-minute YouTube video created by Dr. Mike Evans titled “23 and ½ hours—The Single Best Thing We Can Do For Our Health” (<http://www.youtube.com/watch?v=aUaInS6HIGo>). This engaging video, which presents the case for the importance of regular physical activity to health, was posted on YouTube in 2012 and to date has garnered nearly 3.5 million “views”.

Make sure that our data speak directly to decision-makers—Scientists are trained to be thorough, complete, and appropriately restrained in communicating our evidence to the public. Yet, such an approach can lead decision-makers to overlook scientific evidence amidst the sea of issues vying for their attention every day. Eschewing the more typical scientific “facts and figures” approach to communicating scientific evidence, health professionals such as Dr. Matthew Kreuter have worked to develop brief, engaging informational videos on topics such as smoking prevalence specifically targeted to inform

and catalyze policy-makers in his own state of Missouri (<http://hcrl.wustl.edu/HCRL/projects/CECCR/ARRA/APRC.php#videos>). Targeting such communications to the local level can help to break through the cacophony of issues surrounding both policy makers and the public alike.

Among the steps that researchers can take in engaging policy makers are the following:

- *Be proactive in getting the word out* about our scientific “success stories” through contacting our institutions’ media services groups to develop press releases; sending a condensed locally relevant scientific story to key “gate-keepers” in our locale; and sending scientific press releases to the Society of Behavioral Medicine national office. Spreading the word about behavioral medicine research results can be accelerated further through employing a community-based participatory research perspective (34).
- *Help people visualize the issue* by framing scientific results in ways that speak directly to what people know and can imagine. For example, an Institute of Medicine report suggested that 44,000 or more Americans may die each year as a result of medical errors (35). In contrast, an American Association of Retired Persons (AARP) Report framed similar statistics in a more accessible way through noting how the number of patients who die each year from hospital errors may “*be equal to 4 jumbo jets crashing each week*” (AARP.org, March 2012).
- *Engage the public with our own evidence-based narrative related to an important health issue.* An example of such an approach can be found in Dr. Paul Offit’s book titled “Deadly Choices: How the Anti-Vaccine Movement Threatens us all” (21), a direct response to the antivaccine crusaders.

Additional Areas for Behavioral Medicine Engagement

Exploring ways to engage the public and policy makers with our evidence-based success stories is one of a number of emerging areas of relevance to the behavioral medicine field currently. Four other areas offering particular opportunities for the field are discussed briefly below.

Expand Interdisciplinary Connections into New or Less Explored Areas

As the health challenges facing the U.S. and a growing number of countries worldwide grow in complexity, new ways of looking at these major health problems are increasingly required. Only through embracing new paradigms and approaches can truly transformative solutions be found. This type of transformative science is most likely to be found at the intersection of a number of different fields and disciplines. Table 1 contains examples of disciplines that behavioral medicine researchers may find particularly stimulating as partners. Currently, individuals representing many of these disciplines have attended at least one of SBM’s annual conferences. Our continuing goal as an interdisciplinary organization and field should be to broaden our scientific collaborations and organizational membership activities to include such disciplines.

What we can do—Among the activities that SBM can support to help germinate connections with other fields are: a) highlight presentations focusing on such disciplines in the SBM annual scientific sessions; b) spotlight relevant interdisciplinary work in these areas in SBM journals; c) help behavioral medicine researchers learn the basic “language” of such fields through developing “basic things that you wanted to know about [*field X*] but were afraid to ask” primers or similar types of communications; d) announce or offer training opportunities related to the parsimonious collection of cost data to inform cost

analysis and better define the “value added” by our interventions; and e) continue to broaden the excellent work being done by the SBM Scientific and Professional Liaison Council in this area. On an individual level, some research teams have expanded both their interdisciplinary understanding and research portfolios through engaging in active information exchanges in the form of “cultural visits” or observations with colleagues from another field. Among other steps that behavioral medicine researchers can take are adding a student, consultant, or scientist from other disciplines to our teams.

“Grow” Activities Aimed at Emerging Technologies

The global explosion of communication technologies across virtually all population sectors presents an increasingly fertile area for behavioral medicine research. This is particularly the case given the current lack of systematic evidence demonstrating actual efficacy of the thousands of internet and mobile health (mHealth) programs and applications (apps) available targeting health behavior change or health outcomes (36). Current technological advances allow unparalleled access to assessment (e.g., ecological momentary assessment) and intervention strategies embedded in real-time. Such advances potentially allow for a much better understanding of the myriad ways in which a person’s daily context affects health behaviors and symptoms.

The communication technology “revolution” has been accompanied by a number of challenges as well, including a heretofore unheard of quantity of dynamically collected data requiring or unleashing new analytic strategies and approaches (e.g., control systems models) (37); a demand for new funding paradigms to allow scientific activities in the field to keep pace with the dizzying advances occurring in the information technology sector; as well as the threat of a widening health disparities “gap” if eHealth program development remains insensitive to language, education, and health literacy differences (38, 39). Behavioral medicine has much to offer in each of these areas, and current activities in the field bode well for impacting the health IT “space” in potentially powerful ways (40). In particular, the use of behavioral science evidence to create applications that can substantively address the “whiches conundrum” (i.e., which programs for which people under which circumstances to achieve which outcomes) (41) could be transformative.

With indications that Science itself is increasingly being threatened by ideological forces that have attempted to diminish its value to society, information technologies can also be harnessed to educate and engage the public around science as well as health. A good example of this is the “Tinker” project developed by Dr. Timothy Bickmore and colleagues at Northeastern University. As part of this research endeavor, a “virtual docent” kiosk has been stationed at the Boston Museum of Science (42). Among the functions that the docent has been programmed to perform are giving directions and descriptions of exhibits, as well as providing information about how the docent herself “works”. With content tailored to each user’s computer literacy levels, the virtual docent recognizes return visitors using hand biometrics. It has also presented researchers with a real-world platform for testing the effectiveness of different types of messages to promote enhanced scientific knowledge and engagement. For example, in a recent investigation of over 1600 visitors, half were randomized to interact with a virtual docent that either used a more social-relational style of interacting (including empathy, humor, and personal stories) as opposed to a straight “facts and information” virtual docent. Those randomized to the more socially “competent” virtual docent showed significantly larger increases in knowledge and engagement relative to the “facts and information” docent (42). To date over 50,000 visitors to the museum have interacted with the virtual docent, providing an incredible opportunity to embed science as part of the public experience.

What we can do—Among the diverse sets of activities that SBM members can do in this area are: a) learn about the latest eHealth and mHealth technologies amenable to behavioral medicine intervention, assessment, and dissemination in your field (increasingly being showcased at the annual SBM scientific sessions); b) utilize intramural and other small grant opportunities to begin pilot work and explore cross-disciplinary questions and paths of common interest with technology-oriented colleagues; c) identify potential private sector partners with interests in the health field; and d) connect with the Behavioral Informatics/Health IT Special Interest Group (SIG).

Think Globally

Cutting-edge informational technologies have opened the door to unprecedented opportunities for transcending geographical and political boundaries in attaining global scientific impacts. For example, through “direct to consumer” information technology delivery, “borderless health promotion” has, for arguably the first time in human history, become a real possibility. Among the challenges created by such unparalleled opportunities are the balance and trade-offs between worldwide program reach and the recognition of cultural nuances and differences that make different regions and peoples unique. The long-standing tradition of grounding population-oriented behavioral medicine in community-based participatory research methods and paradigms (34, 43) provides an avenue for identifying not only the behavioral processes and perspectives that we have in common, but also those in which we differ.

As the global drivers of disease mortality and morbidity (among them tobacco use, physical inactivity, and unhealthful diets) become increasingly shared (28), the enrichment afforded by having Society of Behavioral Medicine members from different countries cannot be underestimated. SBM’s recently added Special Interest Group (SIG) on theories and techniques of behavior change interventions is just one example. Founded by an international group of SBM members, an aim of this SIG is to foster a global “shared language” for describing and measuring behavioral medicine interventions. Inter-cultural partnerships also allow us to broaden the generalizability and translation of evidence-based behavioral interventions. A good example of such an endeavor is the Peers for Progress program, aimed at disseminating “best practices” in health-related peer support for diabetes management around the world (44).

What you can do—Among the types of activities that SBM members can do in this area are: a) explore the types of international resources and activities occurring at your institution; b) using the SBM membership list, seek out SBM members from other countries with similar interests; c) consider participating in a cultural exchange or visit abroad to widen your research ideas and possibilities, or host a visiting scientist, student, or practitioner from another country in your unit.

Engage with Policy Whenever Possible

In a fiscal climate in which governmental support for scientific endeavors has become increasingly constrained and “commoditized”, behavioral scientists can no longer “sit on the sidelines” when it comes to policy decision-making. Nor can we ignore the critical importance of impacting public policies that can influence health at the local, regional, and national levels. One approach to engaging more fully in public policy is to seek ways to move successful evidence-based interventions up to the policy level. A striking example of behavioral medicine research that has successfully done so is Dr. Kate Lorig’s chronic disease self-management course. Through a programmatic series of successful research studies, Dr. Lorig and colleagues were able to demonstrate the efficacy, effectiveness, and translatability of this program for diverse populations using different delivery sources and

channels (45). The program became so well regarded at the governmental level that it was specifically named as part of recent U.S. National Health Reform activities that have been promoted.

Another approach to research in the policy realm is to develop studies aimed at evaluating specific policies with direct or indirect links to health. Typically designed as natural experiments or using quasi-experimental methods, such investigations can provide important insights in areas often lacking in evidence. A recent example of such a natural experiment was the recent evaluation of the first national fast food toy ordinance based on nutrition guidelines in Santa Clara County, California (46). The research indicated that the restaurants falling within the ordinance area showed significant improvements in on-site nutritional guidance, promotion of healthy food items, and marketing and distribution activities relative to restaurants from the same chains located nearby, but not falling within the ordinance area (46). A similar ordinance was subsequently passed in San Francisco County, and has been considered in other U.S. cities. A further example of behavioral medicine successes in the policy arena is reflected in the rich history of tobacco control policy research successfully undertaken by a number of outstanding behavioral medicine researchers.

What we can do—The policy arena has become an increasingly fertile area for SBM engagement and activities. Among recent activities occurring in this area are the development of relevant health policy briefs and case statements; targeted Congressional “Hill” visits by SBM Board Members; the creation of an online advocacy tool for facilitating contact between SBM members and legislators around relevant issues; and, as an organization, endorsing legislation of critical importance to the behavioral medicine field.

On an individual level, a way to begin to engage with policy research may be as simple as reading the local paper to become more knowledgeable about policy deliberations with health implications occurring in our own “backyards”. In fact, the fast food toy ordinance study described earlier had its origins in just that type of activity. Spending time with community practitioners and in community settings is another way of hearing about impending policy changes that may represent fertile ground for study. Organizations such as the Robert Wood Johnson Foundation have offered “rapid response” funding to allow for the study of such policy changes that have implications for health. Additional strategies for engaging with the policy arena include meeting with legislators from your district when they are in their home offices during congressional recesses; circulating policy briefs and materials from the SBM website; following your legislators’ voting record on relevant health-related legislation and registering your reactions (both positive and negative) to their activities; and contacting the SBM Public Policy Leadership Group (PPLG) chair about relevant training in the health policy area.

It Takes a Village to “Grow” (and Maintain) a Successful Behavioral Scientist

Finally, in developing a productive and satisfying career, the unquestionable importance of mentors and other “helping hands” along the way has become abundantly clear to those of us who have traveled our own professional “roads” for a number of years. Often such support may come in the form of “random acts of kindness”, with the deliverer frequently unaware of the import of his or her help on the career development of a junior colleague. Throughout my own career, I have been touched in innumerable ways by such acts. One of the jobs of senior colleagues is to seek out ways, large and small, to “pay forward” such positive acts to others who may cross our paths. Meanwhile, the “job” of more junior colleagues and trainees is to embrace such offers when they occur, seek out career development activities when currently none come one’s way, and remain open to taking the risks and making the mistakes that are at the heart of every successful career.

Among other key “life lessons” that I have learned along my journey are: a) follow one’s “gut” (and avoid becoming enslaved to “shoulds” or “musts”); b) serendipity happens but, at the heart of things, you make your own “luck”; c) nothing succeeds like perseverance (but it is also important to know when to stop and accept defeat with dignity); and, d) in the words of the author Henry James, “There are three things in human life that are important: the first is to be kind; the second is to be kind; and the third is to be kind”.

In addition to such personal life lessons, I challenge the behavioral medicine field to actively seek out ways to grow the larger “forest” representing our field as a whole, in addition to growing the individual “trees” working in that field. One essential way of doing that is to actively instill the belief across our discipline that what we do in the research, practice, and policy arenas *is* of central importance and *can* make a fundamental difference to the health and welfare of the population. But we must do this together as a field, embracing the fact that if one of us “wins”, whether it involves being awarded a grant, an honor, or something similar, all of us win. We must become our own advocates for our field, whether occurring through the ways that we review grants or manuscripts; through writing commentaries that shine a spotlight on behavioral medicine’s perspectives and contributions to the major issues of the day; or through linking media stories about our research to the field of “behavioral medicine”. Out of such steps will grow a larger understanding of the behavioral medicine field. For it has become abundantly clear to me as I travel my own career path, that our most powerful “weapon”, in the final analysis, is Us. With the energy and irreverence brought by our more junior members, the passions and creativity of our mid-career members, and the leadership and wisdom of our senior members, we can collectively make a difference in the world. I look forward to continuing our journey.

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Table 1

Examples of Disciplines with Increasing Relevance to Behavioral Medicine (in alphabetical order)

Communication	Medical Anthropology
Computer Science	Medical Informatics
Engineering	Neuroscience
Environmental Sciences	Oral Health
Genetics	Social Work
Geography	Sociology
Health Economics	Statistics/Study Design Methods
Law/Policy	Systems Science