

## Introduction to the special series: translating behavioral medicine research to prevent and control the spread of COVID-19

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Cite this as: *TBM* 2020;10:817–818  
doi: 10.1093/tbm/lbaa093

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We know how important motivation and protective actions are to people's health and well-being. But just in case that lesson has been dulled, the global coronavirus pandemic serves as a sharp reminder. Consider the most often-cited refrain for preventing the spread of this devastating disease: wash your hands, wear a mask, stand 6 feet apart, and do not congregate in large groups of people. Soon, hopefully, we will add a fifth health behavior to the list: get vaccinated.

Drawing from the rich and deep traditions of the field of behavioral medicine, and translating what is known to what remains largely unknown about the coronavirus, behavioral medicine can offer a roadmap to researchers, clinicians, and policymakers to accelerate the tempo of those discoveries and help keep the public safe.

Consider recent appeals from leaders of very large-scale clinical trials that are essential to developing and testing the safety and efficacy of vaccines against COVID-19. These will require many tens of thousands of individuals, including those historically underrepresented in biomedical research, to volunteer. Can U.S. society overcome its fierce independence to now think and act more collectively for the common good? Will we, as individuals, demonstrate solidarity with one another, and proverbially and literally roll-up our sleeves and take a shot in the arm? Let's hope so.

We have reason to believe that we can and will undertake a move toward more collective action. In times of distress, human nature drives us toward each other. How can we reconcile this need with the need for social distancing? After many natural and man-made disasters, history shows us that people come together. The images we sometimes see on our screens of others behaving in ways that subvert the common good can be counteracted by other, better, exemplars of collective behavior: hand washers, mask wearers, and social distancers. Despite the many challenges, often political, behavioral medicine has the tools to empower individuals and society to change behavior and adhere to public health policy guidance.

Shockingly, what we now have is a behavioral adherence problem on a grand societal scale. As

clinician scientists and public health practitioners, we rely on our long-term evidence to guide the development and evaluation of risk communication messages as a key channel to address adherence to health recommendations. Behavioral medicine must continue to translate, disseminate, and implement what we know to other constituencies, including politicians, providers, and policymakers who are confronting behavioral nonadherence on an unprecedented level, particularly in certain regions of the USA. Based on the evidence and theories of health behavior change accumulated over many decades of research, together we can help provide messages to individuals that do not create fear but also do not create complacency.

Behavioral science can help providers, practitioners, policymakers, and community advocates recognize that this global pandemic is an extraordinary stressor and health threat. A substantial body of research shows that not all will cope during crises the same way. Some (aka "monitors") attend to the threat, magnify it, and are more likely to adhere to guidelines. However, they suffer most in the sense that they may overexpose themselves to threatening information and viral rumination. Others (aka "blunters") deny the threat, feel more invulnerable, and may be less likely to adhere to public health directives.

Other factors, of course, influence these outcomes as well. Foremost among them is the need for leadership at the national level, providing consistent messaging about the nature of this pandemic and the public health solutions required, as well as skillful and ubiquitous use of the media in its many and varied forms to communicate those messages. Ultimately, these approaches must be guided by the best science and appropriate and transparent use of the data obtained to monitor overall public health, identify cases to provide best treatment, conduct contact tracing, and isolate as needed. Unfortunately, the USA has not fared well so far in implementing effective strategies to manage this pandemic. What we have seen instead is the lack of a coordinated national strategy, inconsistent messaging, minimal use of the media, inefficient systems of testing, and

a preference for political spin in place of objective scientific facts and leadership from public health experts.

Our field's knowledge base of strategies to prevent and control COVID-19 is growing rapidly, and we anticipate that new scientific findings and evidence-based reviews will continue to guide us in the work we do to combat this pandemic. The previous issue of *Translational Behavioral Medicine* was headed by an editorial concerning the importance of social support in coping with pandemic stress [1], as well as a commentary providing recommendations for COVID-19-related research and policy, particularly as it pertains to underserved populations [2]. Moving forward, *Translational Behavioral Medicine* is offering an ongoing, special series of papers that have been curated specifically for our readership and submitted in direct response to the growing crisis. Within the pages of these articles, you will find empirical research and commentaries at the interface of behavioral medicine and the novel coronavirus. We are focusing on editorials and commentaries, as well as empirical research addressing multiple components of this health crisis, including behavioral and psychosocial risk and resilience factors across the lifespan for various health conditions and populations.

The current issue includes six papers addressing diverse topics related to the pandemic, including health care of youth with diabetes, pain management, physical activity and fitness apps, conspiracy beliefs, and intentions to engage in preventive behaviors, as well as a discussion of social and behavioral research opportunities at the National Institutes of Health. We expect that these papers will be of value to you now and in the time to come as we continue to conduct translational research aimed at improving the delivery of behavioral health care and care of the population.

As part of this rapid response initiative, we seek to lead the dialogue so that the field can have a more informed evidence base of the responses of disadvantaged communities to COVID and address changes that are desperately needed to the structural and interpersonal systems that promote racism and other forms of disempowerment. For these, we must prioritize changes in policy that move away

from the idea of disadvantage and embrace health equity. For example, the alignment of health insurance to employment is a problem during times of high unemployment. Expanding state-based insurance systems and considering other models of providing health insurance to disadvantaged groups may help to alter the structures that maintain ill health among minority populations and is a necessary step in changes we could make to improve population health in general and during COVID. We look forward to seeing more work addressing these issues.

Controlling the COVID-19 pandemic surely requires both policy-level intervention and individual behavior change alike. The costs and risks of not doing so are too great. Ultimately, this is a litmus test of our field's ability to lead on issues such as health messaging and communication and adherence promotion, especially over time. We anticipate that another major issue will soon face us after the development of a safe and effective vaccine—reluctance of many to take the vaccine based on fear and faulty beliefs. We are counting on you, and all of us, to work together to help solve this for the betterment of all of society. Besides moving the field forward and translating findings to promote societal health, we must also look to advocacy and health policy research in these extraordinary times.

**Acknowledgments:** This work was guided by the previously published opinion article authored by Drs. Suzanne Miller and Alan Delamater in the *The New Jersey Star-Ledger* on April 18, 2020.

**Funding:** This work was supported by U01OH011690 from the Centers for Disease Control and Prevention of the Department of Health and Human Services; R01CA224918 and P30CA06927 from the National Cancer Institute of the National Institutes of Health; and a Research Scholar Award by the American Cancer Society (RSG-15-021-01-CPPB).

**Conflict of Interest:** The authors have no conflicts of interest to declare.

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