Welcome to the University of Delaware

on behalf of the Dept of Psychology
“Everybody and their grandmother are talking about ‘evidence-based practice’, but there is a vast disagreement about what counts as ‘evidence’.”
The schizophrenogenic mother
The schizophrenogenic mother

The excessive biological reductionism of the Decade(s) of the Brain

“Depression is a chemical imbalance”

“Schizophrenia…is a debilitating neurological disorder…”

“Mental illness are … brain disorders.”
The schizophrenogenic mother

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Gene x environment interactions as where the action is in psychopathology
The schizophrenogenic mother

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Gene x environment interactions as where the action is in psychopathology

Cognition as a drug target and a treatment outcome measure
“Now that we have the genome…”

But: “The impact of individual genes on risk for psychiatric illness is small, often nonspecific, and embedded in causal pathways of stunning complexity…

Although we may wish it to be true, we do not have and are not likely to ever discover ‘genes for’ psychiatric illness.”

“If the impact of genetic risk factors is *mediated* through environmental processes, this opens up new possible modes of prevention.”

Genes and environments **both** contribute to healthy function, to dysfunction, to healing.

E.g., *environment drives gene expression*, on multiple time scales.

**Both** psychological and biological interventions alter **both** psychological and biological function.
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E.g., environment drives gene expression, on multiple time scales.

Both psychological and biological interventions alter both psychological and biological function.

We are way past “nature vs. nurture”
Now in recovery from the Decade(s) of the Brain, NIH has a new goal:

“the age of symptomatic diagnosis and current generation treatments is passing…

“interventions based in neuroscience already are beginning to drive rapid and dramatic shifts in drug, biological, device, and psychosocial intervention development”
Clearer, narrower psychological constructs, better connected to neuroscience, not reducible to neuroscience

→

Better psychological inferences
Better psychology / biology integration
Better assessment, prevention, and treatment

Psychosocial interventions are back!
Now that NIH has the psychological – biological pendulum under control…

What counts as evidence, especially in research on psychosocial intervention and dissemination?

What can we infer, from what kinds of evidence?
Nowadays, we view “empirical” science as synonymous as good science.
“Empirical”

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“relying on experience or observation alone without proper regard for considerations of system, science, and theory”

“a former school of medical practice founded on experience without the aid of science or theory”

“befitting a quack or charlatan”

Webster’s Third New International Dictionary, Unabridged (1981), p. 743, emphasis added
An issue some clinicians raise about empirically supported or evidence-based treatment:

Do you go with your gut, or with the treatment manual?

Do you trust your subjective experience of the client in front of you, or rely on far-removed research?
British Empiricists

the introspection of Wundt and Freud

the subjectivity of Carl Rogers and Fritz Perls…
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Relying on a therapist’s subjective experience of the client

– and basing intervention choices on that –

is thoroughly “empirical”

But not good enough for dissemination science
Freud relied on a concept of the unconscious

So do modern cognitive and social psychologists

They use **public** data to make inferences about **private** events

They differ in how close those inferred events are to observable data

– what events are inferred, from what evidence
Like the concept of an unconscious, the therapist’s subjective experience can have a role in clinical science…

…but not as scientific data

Scientific evidence is not “empirical” in the historical sense

Scientific data have to be public
Intervention, Implementation, Dissemination

Much will be asked of you the next couple days…

What concepts to use, what theories to teach, what practices to practice?

How to train students as good clinical scientists in all these areas?

And in each area, what counts as evidence?
“My lab doesn’t do dissemination research, my lab is pristine”
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“Dissemination is dirty”
Please, get your hands dirty the next couple days!