



THE DELAWARE PROJECT



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NIMH



NIDA NATIONAL INSTITUTE
ON DRUG ABUSE



National Institutes of Health (NIMH, NIDA, OBSSR);
Academy of Psychological Clinical Science (APCS);
SAGE; University of Delaware

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

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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.”

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Gene x environment **interactions** as where the action is in psychopathology

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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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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

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“befitting a quack or charlatan”

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”



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Please, get your hands dirty the next couple days!