CHAPTER 1

SOCIAL AND CLINICAL PSYCHOLOGY UNITED

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Until quite recently social psychologists were preoccupied with the study of the interpersonal determinants of thought, feeling, and action. Their work was primarily theoretically driven, the behaviors they sought to explain were the sort that occurred in everyday settings, and they preferred to test their hypotheses through laboratory experimentation. Clinically oriented psychologists, in contrast, sought to understand the causes of and cures for dysfunctional behavior. Psychologists in counseling, community, and clinical settings were concerned with developing effective treatments and diagnostic techniques, the behaviors they puzzled over were abnormal ones, and they preferred to test their hypotheses in field settings.

A change, however, has been taking place at the borderline between social and clinical psychology. Although the benefits of an integrated social-clinical approach were recognized in 1966 by Goldstein, Heller, and Sechrest in their book *Psychotherapy and the Psychology of Behavior Change*, and were reiterated a decade later in Brehm’s 1976 book *The Application of Social Psychology to Clinical Practice*, it was not until the 1980s that this interface became truly viable. Now, for example, we find that social psychologists, who recognize the potential applicability of their theories to clinical practice, are exploring sources of dysfunction and suggesting socially based treatment strategies. Likewise, clinical, counseling, and community psychologists, who recognize the role of interpersonal dynamics in adjustment and therapy, have begun to synthesize social psychological principles and clinical practice. This collaborative, cross-disciplinary movement is producing a growing interface between psychology’s helping professionals and social psychology (e.g., Brehm & Smith, 1986; Dorn, 1984; Higginbotham, West, & Forsyth, 1988; Leary & Maddux, 1987; Leary & Miller, 1986; Maddux, Stoltenberg, & Rosenwein, 1987; Shera & Worcel, 1979; Snyder & Ford, 1987; Weary & Mirels, 1982).

In this chapter we present an overview of this interface. First we consider, in brief, the traditional goals of social and clinical psychology, where the word *clinical* is used in the “small c” sense, which includes such subspecialties as clinical, counseling, and community psychology. Second,
we enumerate the qualities that emerge when these two areas of psychology are linked together into a single perspective. This analysis maintains that the social/clinical interface not only provides insight into the factors that produce dysfunction and foundations of effective treatment, but also innumerable insights into the factors that operate to sustain psychological health on a day-to-day basis. In this latter vein, the chapter concludes with a presentation of a proposed health-help-health framework for understanding much of the recent work in the interface of social and clinical psychology.

A BRIEF HISTORY

The philosopher of science Thomas Kuhn, in his provocative book The Structure of Scientific Revolutions, argues that scientists working in a particular field often share a set of assumptions about the phenomena they study (Kuhn, 1970). His thesis is that when individuals are trained to be scientists, they learn not only the content of the science—important discoveries, general principles, facts, and so on—but also a way of looking at the world that is passed on from one scientist to another. This paradigm consists of a set of shared fundamental beliefs, exemplars, and symbolic generalizations, and it provides researchers with a world view that determines the questions they feel are worth studying and the methods that are most appropriate.

Historically, social and clinical psychologists have adopted differing paradigms. Although the two emerged within psychology at almost the same time, their differing concerns prompted them to develop divergent perspectives on human behavior. As the following brief review of historical trends in the two fields indicates, by tradition the questions raised by social psychologists focused their interest more on exogenous determinants of normal actions, whereas the questions raised by clinical psychologists drew them toward the study of endogenous determinants of abnormal actions.

Development of a Social Psychological Outlook

Social psychology, despite its ancient roots in the writings of philosophers and scholars, did not emerge as a unified subfield within psychology until the 1940s. Granted, certain social psychological phenomena, such as individuals' performance in the presence of others (Triplitt, 1897) and mob behavior (Le Bon, 1895), had been the target of scrutiny before the turn of the century. But as Cartwright's (1979) historical account of the field notes, these varied efforts remained relatively uncoordinated during the years that psychodynamic perspectives and behavioristic tenets shaped most psychologists' thinking.

The late 1930s and the 1940s, however, saw the gradual emergence of a set of core assumptions that provided the foundation for a contemporary social psychology. Moving away from the cultural perspective emphasized by anthropologists and the broad societal view embraced by sociologists, social psychologists within psychology firmly reiterated their focus on the individual. Social psychology, as Gordon W. Allport writes, was considered "above all else a branch of general psychology" (1985, p. 3). Social psychologists, however, claimed to be uniquely interested in how individuals influence and, in turn, are influenced by other people. Let other psychologists study neural structures, psychophysics, sensation and perception, and adjustment; social psychologists staked out the person in the social context as their domain.

Social psychologists did not, however, restrict themselves to the study of situations that required interaction among individuals. Although they were concerned with social behavior, their psychological bent led them to consider both endogenous and exogenous processes. An attitude, for example, was thought to be an affectively valenced mental state of readiness (Allport, 1985). Yet, this purely intrapsychic process became a "primary building stone in the edifice of social psychology" (Allport, 1985, p. 37) because researchers assumed that attitudes profoundly influenced, and were profoundly influenced by, the social world. Thus, rather than restrict their investigations to overtly social processes, social psychologists chose to investigate individual differences, personality traits, attitudes, values, motivation, emotion, and social cognition as well as attraction, influence, and group processes.

To some, the social psychologists' interest in interpersonal factors seems misplaced. Carlson (1984), for example, criticized social psychologists for not restricting their investigations to the interpersonal realm. She argued that "solid social psychology" required studying naturally forming social groups, interaction among "real" individuals.
the impact of social structural variables such as gender or race on behavior, and social issues such as political disputes or racism. Yet, as Kenrick (1986) explains in a rejoinder, most (but certainly not all) social psychologists adopt a broader, more balanced view of their field. Gordon W. Allport captured this outlook when he defined social psychology as “an attempt to understand and explain how the thought, feeling, and behavior of individuals are influenced by the actual, imagined, or implied presence of others” (1985, p. 3). Similarly, Kurt Lewin (1936, p. 12), a key figure in the founding of social psychology, wrote, “Every psychological event depends upon the state of the person and at the same time on the environment” and formalized this assumption in his equation \( B = f(P, E) \). Although the \( P \) (person) in the equation is sometimes slighted relative to the \( E \) (environment), social psychologists continue to espouse the doctrine of interactionism.

With this growing recognition of the importance of both personal and situational factors came major advances in methodological sophistication (Cartwright & Zander, 1968). Reacting in part to Floyd Allport’s influential 1924 text that demanded greater attention to scientific rigor, researchers managed to develop more precise measurement methods (Thurstone, 1928) and more elaborate experimental procedures (Murphy & Murphy, 1931). As Table 1.1 indicates, as early as 1928 Louis L. Thurstone published his precedent-setting paper titled “Attitudes Can Be Measured.”

In 1936 Muzaffer Sherif demonstrated that a perceptual process can be influenced by an experimentally manipulated social norm. In 1939 Kurt Lewin, Ronald Lippitt, and Ralph White published their study of group members’ reactions to leaders who adopt autocratic, democratic, and laissez-faire styles of leadership. And by 1943 Theodore Newcomb’s so-called Bennington Study linked changes in attitudes to social pressure. These studies not only illustrated the potential of the social psychological perspective, but also provided models for how research should be carried out (Jones, 1985).

Social psychology’s gradual development of a set of basic theoretical and methodological premises was accelerated by the Second World War. Scholars and researchers who were trained as social psychologists assisted in the war effort by examining a range of applied topics, including civilian and troop morale, changing attitudes through persuasion and propaganda, improving organization in fighting units, and international relations. Dorwin Cartwright, in reflecting on this period, pointed out that this applied work changed the face of social psychology, for it “provided concrete examples of the practical usefulness of social psychology” (1979, p. 84). Moreover, it solidified the link between social psychology and social issues. Researchers expanded their investigations beyond theoretically interesting ideas to include the analysis of social problems, including conflict, racism, and environmental degradation.

Social psychology continued to develop during the postwar years, particularly in the realm of theory construction (see Table 1.1). Yet, in general these developments were consistent with the methodological and theoretical tenets established by earlier researchers and theorists: What was the goal of the field? Explain social behavior. What was the fundamental theoretical assumption? Social behavior depends on aspects of the individual (intrapersonal processes) and aspects of the situation (interpersonal processes). How should this assumption be tested? Through rigorous research; experimental, if possible. New ideas continued to influence the field, but the basic tenets that initially prompted the emergence of this subdiscipline continue to manifest themselves in contemporary social psychology.

**Development of the Clinical Psychology Outlook**

The era that witnessed the gradual growth of social psychology also watched clinical psychology develop into a dominant force within psychology and among the health-care professions. As was the case with social psychology, the seeds of the present-day field were sown gradually during the early part of this century (Table 1.2). At this time the treatment of psychological disorders was, in general, the physician’s private domain. Some psychologists, such as Witmer, were actively treating clients with speech disorders and learning disabilities as early as 1896, but these practitioners were a rare breed (McReynolds, 1987). Their efforts were based on the then-radical idea that psychologists should not just generate information about human behavior, but also seek the “application of psychological principles and techniques to the problems of an individual” (Watson, 1951, p. 5). To the consternation of many psychologists (both then and perhaps even now), these clinicians
Table 1.1. Prominent Events in Social Psychology, 1897–1959

<table>
<thead>
<tr>
<th>YEAR</th>
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<tr>
<td>1897</td>
<td>Tripplett publishes the results of a laboratory study of social facilitation</td>
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<td>1908</td>
<td>Publication of the first texts in social psychology</td>
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<td>1924</td>
<td>F. A. Allport presents a scientific framework for the study of social processes</td>
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<td>1928</td>
<td>Thurstone proposes &quot;Attitudes Can Be Measured&quot;</td>
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<td>1936</td>
<td>Sheriff reports his study of conformity to group norms</td>
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<td>1939</td>
<td>Lewin, Lippitt, and White publish an experimental study of leadership style and performance</td>
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<td>1953</td>
<td>One of many monographs on communication and attitude change is published by Hovland, Janis, and Kelley</td>
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<tr>
<td>1954</td>
<td>Publication of G. W. Allport's <em>The Nature of Prejudice</em></td>
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<td>1957</td>
<td>The first modern edition of the <em>Handbook of Social Psychology</em> is published</td>
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<td>1958</td>
<td>Festinger's <em>A Theory of Cognitive Dissonance</em> sparks two decades of research on attitude change</td>
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<td>1959</td>
<td>Heider's <em>Psychology of Interpersonal Relations</em> set forth the tenets of attribution theory</td>
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<td></td>
<td>Thibaut and Kelley publish <em>The Social Psychology of Groups</em></td>
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were suggesting that psychology was a profession as well as a science.

Psychologists also found considerable success when they used their psychometric skills to develop reliable measures of cognitive abilities and personality functions. At first, these tests were designed primarily for use in identifying children with special educational needs, but World War I stimulated the development of a number of batteries that could be used for measuring individual differences in adults. This emphasis on assessment, once established, continued into the 1920s with the publication of such tests as the Seashore Musical Ability Test (1919), the Woodworth Personal Data Sheet (1920), the Rorschach Inkblot Test (1921/1942), and the Goodenough Draw-A-Man Test (Buros, 1938).

Assessment, and its attendant focus on individual differences among individuals, stimulated theoretical analyses of the nature and function of personality. This intrapsychic perspective was all the more reinforced by the advent of Freud's psychodynamic model of behavior disorders. Many clinicians worked closely with physicians at a time when Freud's views were revolutionizing the medical world's view of psychological abnormalities, so it is not surprising that clinical psychology began to link disordered behavior to disturbances in personality structure and development. Although clinicians weren't directly involved in treatment during these early years, the influence of Freud's thinking could be seen in their projective assessment methods and the rapid proliferation of personality theories that yielded clear predictions about the causes of abnormal behavior.

Despite continual advances in application, assessment, and theory, clinical psychology did not begin to thrive until World War II created a demand for trained mental health professionals. Clinical psychologists' specialized assessment skills proved invaluable to a nation at war; indeed, in 1944 alone nearly 20 million soldiers and civil-

Table 1.2. Prominent Events in Clinical Psychology, 1890–1953

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<th>YEAR</th>
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<tr>
<td>1890</td>
<td>James McKeen Cattell describes the development of &quot;mental tests&quot;</td>
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<td>1896</td>
<td>Witmer becomes the first &quot;clinical&quot; psychologist when he opens a clinic at the University of Pennsylvania</td>
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<td>1909</td>
<td>Freud's lectures at Clark University spark widespread acceptance of his ideas by the medical community</td>
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<td>1916</td>
<td>Publication of the Stanford-Binet test of intelligence</td>
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<td>1924</td>
<td>A test-publishing firm, the Psychological Corporation, is founded by James McKeen Cattell</td>
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<tr>
<td>1936</td>
<td>Luntt publishes the first test titled <em>Clinical Psychology</em></td>
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<td>1942</td>
<td>The first <em>Buros Mental Measurement Yearbook</em> is published</td>
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<tr>
<td>1946</td>
<td>Carl Rogers' <em>Counseling and Psychotherapy</em> is published</td>
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<tr>
<td>1949</td>
<td>Veterans Administration supports the training of clinical psychologists in assessment, diagnosis, and treatment</td>
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<tr>
<td>1949</td>
<td>The &quot;Boulder model&quot; is adopted as the standard of training in clinical psychology</td>
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rians were assessed via written instrumentation or interview (Reisman, 1976). The war also took a huge toll in terms of psychological casualties, and this flood of persons in need of treatment opened the door for clinical psychologists to become therapists. This demand for human services prompted the Veteran's Administration, at the war's end, to recognize officially clinical psychology as a health-care profession. With this mantle and the promise of federal assistance in training clinical psychologists came the opening of the first Ph.D. programs in clinical psychology.

The bulk of these programs based their students' educational experiences on the recommendations offered by American Psychological Association's Committee on Training in Clinical Psychology (1947). Shakow, who was the chairperson of the committee, summarized the key principles as follows (1978, p. 151):

1. A clinical psychologist must be first and foremost a psychologist.
2. The program for doctoral education in clinical psychology should be as rigorous and as extensive as that for the traditional doctorate.
3. Preparation should be broad; it should be directed toward research and professional goals.
4. In order to meet the above requirements, a core program calls for the study of six major areas: general psychology, psychodynamics of behavior, diagnostic methods, research methods, related disciplines, and therapy.
5. Programs should consist mainly of basic courses in principles, rather than the multiplication of courses in technique. The specific program of instruction should be organized around a careful integration of theory and practice, of academic and field work, by persons representing both aspects.

This model of graduate training was subsequently adopted at a national training conference held in Boulder, Colorado, in 1949, and hence became known as the Boulder model (Rainy, 1950).

Clinical psychology continued to develop during the postwar years. New treatment perspectives, particularly those focusing on behavioral and phenomenological models, began to supplant the uniform reliance on psychodynamic models. Differences in emphasis resulted, in time, in the emergence of alternative models for understanding psychological problems and for delivering mental health services, including counseling psychology, and community psychology. Overall, however, clinical psychology continued to expand along the philosophical lines established at the time of the Boulder Conference: What was the goal of the field? To identify and apply psychological principles to prevent and treat psychological problems. What was the fundamental theoretical assumption? That dysfunctional behavior stems from intrapersonal processes, including disturbances of personality and adjustment. How should this assumption be tested? Through rigorous research, with a strong emphasis on accurate assessment in clinical settings.

FOUNDATIONS OF THE SOCIAL/CLINICAL INTERFACE

When is a relationship between two people satisfying and long-lasting? Experts and laypersons tend to invoke one of two basic tenets in answer to this question. Some cite the principle of similarity; they note the striking unity of the characteristics, needs, and goals of the two parties involved and conclude that “birds of a feather flock together” (Byrne, 1971). Believers in the principle of complementarity, in contrast, attribute the relationship's longevity to the way each party's unique qualities mesh with the qualities of their partner (Snyder & Fromkin, 1980). The two can be so dissimilar as to be opposites, but when they join together a strong bond is formed; after all, “opposites attract.”

Although social psychology and clinical psychology are two disciplines rather than two people, their interface is based on these two principles. As the historical trends described above suggest, social and clinical psychology's paradigmatic assumptions overlap to a degree, yet they also conflict. The two disciplines share important similarities in goals, methods, and theory. Both fields, for example, are branches of psychology, both seek to explain behavior, and both rely on a variety of empirical methods to achieve answers (Forsyth & Strong, 1986).

These similarities provide fundamental linkages between the two disciplines, but the value of their interface derives more from their dissimilarities. As the ancient concept of yin and yang argues, profound advances in knowledge often require the synthesis of opposites. In the historical differences between social and clinical psychology lies the present promise of the social/clinical interface. When integrated, the emergent interface embraces
theoretical and methodological approaches that have previously typified only one or the other of social or clinical fields. In this section the unique metatheoretical and epistemological qualities of the interface’s paradigm are considered.

Metatheoretical Assumptions

The social/clinical interface seeks to avoid the bifurcation of science into basic and applied. The boundary line between basic and applied research is not clear-cut, but philosophers of science highlight the different goals of basic and applied researchers (Bunge, 1974; Ziman, 1974). Simply put, the goal of basic researchers is the generation of knowledge. Guided by a particular theoretical system, they conduct research that provides critical information about the strengths and weakness of their hypotheses concerning the phenomena of interest. Applied scientists, in contrast, seek information that will increase knowledge while also proving itself to be relevant to some particular problem. In applied science, too, the research may spring from practical concerns as much as from theoretically relevant hypotheses.

This division of effort, however, leads to a variety of problems. On the basic side, researchers often gravitate unerringly toward elaborate theoretical models of behavior that have little or no applicability. Sommer (1982), for example, described a case of basic research gone awry in his analysis of historical trends in Prisoner’s Dilemma (PD) research. As he noted, each study moved further and further away from the original questions concerning bargaining and negotiation. In consequence, “PD research has tended to be drawn from previous PD research, thus creating a hermetic laboratory system without the validity checks and enrichment of experimental conditions that could come from the study of actual cases” (p. 531). In a second example, Glasser (1982) found it odd that basic research in learning over the last three decades has yielded so little insight into the educational process. As he notes, as early as 1900 John Dewey recommended linking theory and educational practice to better understand learning processes. However, for many decades experimental learning theorists worked on their own questions in psychology departments, while educational researchers examined practical problems from positions in education programs. Glasser suggested that the slow progress of educational psychology stems from this artificial separation of basic and applied research.

Hill and Weary (1983) noted that this drift toward increasing theoretical specificity accounted, in part, for the original split between social and clinical psychology. Considerable intermixing occurred in the early days of the Journal of Abnormal and Social Psychology; in time, though, social psychology grew away from application toward more theoretical pursuits. Zajone, one-time editor of the journal, explained that the social psychological work became more theory-driven, whereas the clinical research “was mainly for professional purposes and seldom illustrated some theoretical point” (quoted in Hill & Weary, 1983, p. 9). As a result, the journal split into two, with one focusing on theoretical, mainstream social psychology (Journal of Personality and Social Psychology) and the second focusing on clinical topics (Journal of Abnormal Psychology).

Strong (1987), a long-time advocate of the interface of social and clinical psychology, similarly bemoaned the theoretical excesses in social psychology. Strong (p. 191) lamented that “social psychologists have become obsessed with methodological rigor, theory-driven research, and small-scale theories,” with the result that the great promise of the field has turned into a false hope. Most social psychologists, when asked if their work can be applied to better understand social problems and processes, are quick to cite Lewin’s (1951) maxim: There is nothing so useful as a good theory. What they forget, however, is that Lewin also charged basic researchers with the goal of developing powerful, comprehensive theories that could be tested by applying them in real-world settings. For the interface, if a theory is too narrow and trivial, too broad and general, or just too irrelevant to everyday issues, it is not a very good theory (Forsyth, 1988).

Applied research, too, suffers when separated from the basic (Hill & Weary, 1983; Weary, 1987). When findings are not placed in a larger scientific context, applied research can become too atheoretical. Indeed, when research becomes wholly applied, it also tends to drift toward technology. In science, applied problems may be the initial source of research questions, but these applied concerns are ultimately placed into a theoretical context, and the long-term goal of such research includes testing the adequacy of assumptions and hypotheses that make up the theory. In
technology, on the other hand, theory and methods are used solely to develop some product—such as a new diagnostic instrument, an intake procedure that will satisfy the needs of some treatment agency, or a cost-effective structured training workshop. Technicians are concerned with solving a particular problem in a specific situation without concern for increasing our general understanding of human behavior. While technological researchers may borrow the theories of science to guide their problem-solving, their efforts are not designed to test generalizable propositions derived from these theories. Technological research may generate information that is useful in science—such as providing an indication of what variables are important in a given setting, stimulating research, or refining methodological tools and innovations—but the research is so problem and situation specific that generalizations to other settings are limited.

Without argument, the unique characteristics of psychotherapeutic settings pose special problems for researchers. Indeed, some have argued that the psychotherapy process and problems related to psychological adjustment are so special that they cannot be explained using principles of human behavior derived from the basic side of psychology. One proponent of this view wrote: “as counseling researchers we are interested in developing principles of human behavior only inasmuch as they tap principles of counseling” (Gelso, 1979, p. 14). He continued by suggesting that investigators must keep “actual counseling in central focus” with methodologies that closely approximate ongoing psychotherapy. To one who advocates such insularity, basing explanations of psychotherapeutic processes on principles drawn from basic studies of social psychological propositions is misguided (cf. Garfield, 1979, 1980; Gibbs, 1979).

The interface, however, is based on the premise that social and clinical psychologists share a similar goal: to develop and test generalizable principles of human behavior. Hence, if clinical psychologists explain behavior in terms of propositions that are essentially social psychological in nature, then findings obtained in basic studies of these general statements are necessarily relevant in evaluating the adequacy of these propositions. If, for example, basic researchers find that individuals who feel that they cannot control their outcomes on a laboratory task experience losses of motivation, then this finding lends support to the learned helplessness model of depression (Seligman, 1975). If an attitude change study shows that similarity between the communicator and the audience leads to increased persuasion, then this finding informs analyses of the client-therapist fit (Goldstein, 1971). If researchers discover that individuals who are fairly confident in their perceptions of another person tend to ask this person questions that confirm their original beliefs, then this finding offers insight into the clinical inference process (Murdock, 1988). For the interface, evidence concerning the adequacy of a general principle of human behavior should be drawn from all available sources, whether these sources be basic research or applied research within or outside clinical and counseling psychology.

In sum, if too basic, researchers sometimes develop elaborate theoretical conceptualizations that have little relationship to reality or lose sight of the social value of their findings. But if too applied, research can become theoretically simplistic, situationally restricted, and technologically oriented. The interface, recognizing the limitations of each pursuit, recommends that basic and applied research should be combined if the dynamics of health and abnormality are to be understood. The interface accepts the long-term goal of increasing knowledge and understanding, and insists that data should be relevant to some theoretical construct. The interface, too, assumes that the test of theory lies in objective, empirical methods rather than logical claims or subjective feelings, and it strives for consensus among members of the discipline concerning acceptable, unacceptable, and to-be-evaluated explanations of empirical observations.

The Role of Theory

Social psychologists have a penchant for erecting theoretical systems for understanding human behavior. Adopting a tradition that dates back to Allport's (1924) early insistence that our knowledge of social action must be systematized, social psychologists are skeptical of any observation or finding that cannot be put into a theoretical context. In consequence, much of social psychology's contribution to the analysis of clinical issues occurs at a theoretical level.

This emphasis on theoretical foundations is a potential point of dissension between clinical and
social psychology (e.g., Rogers, 1973; Sarason, 1981; Strupp, 1975; Wachtel, 1980). Some clinical researchers, for example, argue that science progresses through the accumulation of evidence and fact rather than through theoretical accretion. Stressing the empirical side of science, they gather data that pertain to such questions as, Does therapy X work better than therapy Y? Is an elevated score on a certain subscale of the MMPI an indicator of psychopathology? Are therapists' religious values related to their clinical style?

Although all raise important issues, such studies cannot advance our understanding of psychotherapy unless the obtained findings are relevant to trans situational statements dealing with behavior. Facts are used to spin theoretical systems or support existing frameworks, but because of their mutability and situational specificity, facts are of little long-lasting value in science. Specific facts—or, as in this case, empirical findings—are not themselves generalizable, but the hypotheses they either support or disconfirm are. For example, the investigator who finds that therapists who maintain eye contact 60% of the time are more effective than therapists who maintain eye contact 30% of the time may be tempted to tell practitioners to maintain a good deal of eye contact. Unfortunately, the specifics of the setting—the attractiveness of the therapists, the type of clients, the content of the therapists' statements during eye contact—all limit the generalizability of the "fact" that high eye contact makes counselors and clinicians more effective. If, however, the researcher had been studying a higher order theoretical proposition—such as (a) the greater the client's trust in the therapist, the more effective the therapy; (b) ceteris paribus, eye contact implies honesty and openness; and therefore (c) eye contact will create greater client-therapist trust and facilitate therapy—then the study has implications beyond the obtained data. In this latter case the researcher would be scientifically justified in suggesting that therapists establish a deep level of trust with clients, and that this trust could be created by appropriate nonverbal behaviors.

Thus, theory provides the organizing framework for conceptualizing problems, organizing knowledge, and suggesting solutions. Supporting this view, when decision-makers in mental health fields (federal and state administrators of psychological services programs) were asked "What makes research useful?" (Weiss & Weiss, 1981), the conceptualization of the problem (which could include the theoretical framework) was the most frequently noted attribute among both scientists (40%) and decision-makers (29%). Furthermore, when subjects actually evaluated sample studies, their judgments of usefulness were correlated with objectivity, in addition to practical, descriptive, causal, or theoretical knowledge.

Basic theory, too, provides the practitioner with an overall understanding of the therapeutic process. As Maddux (1987, p. 31) explained, because "clinical interventions without theoretical or empirical foundation are likely to be misdirected, a skillful clinical or counseling practitioner must be an astute theoretician and an empiricist."

Granted, this position contrasts sharply with the recommendation to avoid theory because it disrupts the spontaneity of the therapeutic process. As Strupp (1984, 1986) maintained, however, a "scientific attitude" is one of the key elements of a successful therapist. Indeed, Strupp (1975) worried that the erosion of excellence in applied psychotherapy programs was due to the rise of an anti-intellectualism that roadblocks the integration of science and application. Strupp wondered whether the rise of the humanistic, intuitive approaches to therapy results in such an emphasis on feelings over cognitions and emotions over reason to such a degree that models of therapy become little more than "dewy-eyed sentimentality, drivel, or worse" (p. 563). He was particularly strong in his criticism of many humanistic approaches for encouraging the viewpoint that "anyone who advocates study and scientific inquiry is perceived as an enemy of all that is good, open, spontaneous, authentic, beautiful, and enjoyable in human experience" (p. 571). He quoted in this context one sensitivity trainer who told Kurt Back (1972, p. 15), "Do not try to prove things; give yourself a chance to live the experience."

Strupp suggested that such a view makes for bad science and bad therapy. Although the actual practice of psychotherapy may not be science, it can be conducted with a "scientific attitude." A useful theory of psychological adjustment may state that increases in factors A, B, and C will benefit clients with D, E, and F characteristics, but experience in clinical settings may be needed to determine the optimal levels of A, B, and C, techniques to use in varying these factors, and ways to assess D, E, and F. Few theories in psychology are so precise that they yield mathematical statements describing the magnitude of important variables, so practitioners must be prepared
to turn to situation-specific and client-specific research to obtain the precision they require.

Methodological Assumptions

A science's paradigm not only includes meta-theoretical and theoretical beliefs about the phenomena under investigation, but also includes assumptions about the methodological practices that should be used in research. Traditional social psychologists, for example, prefer clearly manipulated independent variables, clever dependent measures, and the control afforded by a laboratory setting. Traditional clinical psychologists, in contrast, argue that the nature of clinical and counseling psychology requires field studies conducted in "real" therapy settings with "real" clients and "real" therapists, and that only findings that can be easily generalized to "real-life" psychotherapy are data worth discussing. Laboratory studies, to the clinician, are at best tangentially relevant to clinical practices and, at worst, completely irrelevant (e.g., Gibbs, 1979; Goldman, 1978).

The relative value of field versus laboratory is a complex question and has been debated in a number of areas of psychology (e.g., Berkowitz & Donnerstein, 1982; Bronfenbrenner, 1977; Dipboye & Flanagan, 1978; Gelso, 1979; Gibbs, 1979; Harre & Secord, 1972; Hernstein, 1977; Jenkins, 1974; McCall, 1977; McGuire, 1973; Mook, 1983; Rakover, 1980). When viewed from the holistic perspective derived from integrating social and clinical assumptions about behavior and basic and applied research strategies, however, the issue becomes less important. First of all, the context in which social behavior occurs must be thought of as only one more variable or dimension that must be interpreted within the larger theoretical scheme. Kazdin (1978, p. 684) made this point clearly when he stated that "research in psychotherapy and behavior therapy can differ from clinical application of treatment along several dimensions such as the target problem, the clients and the manner in which they are recruited, the therapists, the selection treatment, the client's set, and the setting in which treatment is conducted." Importantly, however, increasing the "similarity of an investigation to the clinical situation . . . does not necessarily argue for greater generality of the results." In essence, the importance of the setting must be established empirically (Bass & Firestone, 1980; Berkowitz & Donnerstein, 1982; Flanagan & Dipboye, 1980).

Second, as Mook (1983), Rakover (1980), and Forsyth and Strong (1986) maintained, where a study is conducted is not necessarily related to the theoretical import of the study. Studies conducted in laboratory settings, for example, may still be relevant to nonlaboratory behaviors (or so-called "real" behaviors, as if laboratory behaviors were not) if they examine theoretical generalizations that are relevant to these applied problems. Mook (1983, pp. 386–387) suggested that researchers should continually ask themselves, "Am I . . . trying to estimate from sample characteristics the characteristics of some population? Or am I trying to draw conclusions not about a population, but about a theory that specifies what these subjects ought to do?" If the investigator is concerned with theoretical issues, then generalizability is determined more by the structure of the theory—its scope, specificity, and universality—than by location of the supporting research.

There is little room for methodological snobbery in the interface of social and clinical psychology. The interface suggests that—like eclectic therapists who integrate many theories of psychological functioning when interacting with clients—researchers must also remain eclectic; they must use any and all scientific means possible to gather information concerning the theoretical system under investigation. Whether experimental, correlational, field, laboratory, role-play, or analogue, no opportunity to further our understanding of psychotherapy should be bypassed. As Hilgard (1971, p. 4) noted, in order to "satisfy the criteria of 'good science'" the researcher "must cover the world spectrum of basic and applied science by doing sound (and conclusive) work all along the line."

THE HEALTH PERSPECTIVE

Significant advances often occur in science when scientists in different fields abandon their independent efforts to understand a phenomenon and join together in a united effort. Biochemistry, astrophysics, biophysics, and the social/clinical interface are all examples of scientific fields that resulted from this melding process (Spring, Chiodo, & Bowen, 1987). As noted in earlier sections, the increased unification of social psychology and clinical psychology raises a number of metatheoretical, theoretical, and methodological issues. However, proponents of the social/clinical interface are united in their belief that significant
scientific progress can be achieved through a collaborative, cross-disciplinary integration of social psychological principles and clinical diagnosis, prevention, and treatment (Dorn, 1984; Higginbotham, West, & Forsyth, 1988; Leary & Maddux, 1987; Leary & Miller, 1986; Maddux, Stoltenberg, & Rosenwein, 1987; Sheras & Worcel, 1979; Snyder & Ford, 1987; Weary & Mirels, 1982).

A number of assumptions provide the undergirding conceptual structure for much of the research and theoretical interface work. Without question, the field’s emerging status and its multi-disciplinary roots guarantee disagreements over these assumptions. Nevertheless, by identifying candidates for the conceptual cornerstones of this emerging field, we can better organize and integrate the various topics currently investigated by social and clinical psychologists, and identify directions for future growth.

Our view is that the concerns of the social/clinical psychologists are also the concerns of the health psychologist. Matazzaro (1980, p. 815), who defined health psychology as the “aggregate of the . . . contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness, and related dysfunctions,” could have been defining the social/clinical interface.

Our belief is that health psychology is the wave of the future; in fact, the ripples from a health psychology perspective are already lapping at the shores of psychology. What is especially noteworthy in regard to health psychology is the fact that it has integrated social and clinical psychology from its inception. More than any other area of inquiry, social and clinical psychologists are working together to advance our understanding of health. In this vein, it should be noted that the ideas expressed in this paragraph are shared by leading thinkers at the social/clinical interface (e.g., Harvey, Bratt, & Lennox, 1987; Hendrick & Hendrick, 1984; Matazzaro, 1983; Meyerowitz, Burish, & Wallston, 1986; Rogers, 1983; Spring, Chiodo, & Bowen, 1987).

Although we will employ a health psychology perspective, the reader will recognize the rather easy fit of the social-clinical interface in the various sections of the book. Inherent in our general health approach is the belief that behaviors, including many of those that are often considered “abnormal” or “pathological,” are best understood by examining processes that apply to most people. That certain forms of behavior have a genetic and biological underpinning cannot be denied; nor do we mean to argue against the view that a few behaviors are bizarre. Rather, our meaning is that the key to understanding the bulk of human behavior lies in normal processes that may or may not be working for people. As Maddux (1987, p. 30) put it:

So-called “abnormal” . . . patterns are essentially distortions or exaggerations of normal patterns or normal patterns that are displayed at times and in places considered by those in charge (norm enforcers) to be inappropriate. Thus, the rules that govern normal . . . behavior—whatever those rules might be—also govern or can be used to explain and predict behaviors and social interactions that become identified as abnormal.

This general health psychology approach to the social-clinical interface suggests a health-help-health cycle that serves as organizing principle for arranging the individual chapters in this book. Health, when viewed from a social/clinical perspective, consists of the psychological/physical state that the person is motivated to sustain or change. Several points of elaboration are necessary at this point in order to clarify our use of the term health. Contrary to the conception of health as being a positive state of well-being, which is probably held by both laypeople and most psychologists (especially many of those in the health area), we employ this term in a more neutral sense. For example, the first definition of health in the unabridged Random House dictionary is “the general condition of the body or mind with reference to soundness and vigor.” In this sense, one’s health is not necessarily synonymous with “good health,” but it may vary from very poor to very good health. Also, as we use the term health, we mean to convey, much like the “mind and body” phrasing of the dictionary definition, that the referent of health may either be psychological or physical; moreover, in most instances we would argue that the psychological/physical components are interactively and reciprocally bound up with each other.

For our present purposes, we would suggest that health may be relatively positive, or relatively negative; moreover, one’s state of health may be temporarily confined or more enduring. Among
the myriad of possible motivationally driven sequences, the following are most salient: good health → good health; bad health → good health; bad health → bad health; good health → bad health. In other words, different people may be motivated to act upon their present good or bad level of health so as to continue or change the present level of health. Help in this sense reflects the person’s attempts to sustain or change the state of health (psychological/physical). Additionally, the helping process can originate within the person or it can derive from interpersonal sources. Whatever the outcome of the help, it impacts the person’s initial sense of health. Thus, as the model shown in Figure 1.1 suggests, the health-help-health cycle is a cybernetic system that maintains health through a dynamic interlinking of the personal and environmental (e.g., interpersonal and therapeutic) processes.

As shown in Figure 1.1, the health-help-health model takes a holistic perspective in which health (including adaptive and dysfunctional states as we define it) and the various types of help are components of a unified system that cannot be fully understood by piecemeal examination. Rather than emphasizing endogenous factors relative to exogenous factors or vice versa, the interface considers the interaction of both intrapersonal and interpersonal factors. This view, of course, is consistent with the Gestalt principles that form the foundation of Kurt Lewin’s field theory. Lewin (1936) believed that behavior (B) must be considered to be a function of both the personal qualities of the individual (P) and the characteristics of the environment (E), and he summarized this assumption in his formula B = f(P, E). Applied to the health-help-health cycle, this formula implies that one’s current level of health is a product of processes operating within the individual (e.g., affect, cognition, personality, temperament) interacting with such environmental factors as social support, stressors, and assistance provided by health-care professionals (Hendrick & Hendrick, 1984). All of these factors, when considered as a totality, form what Lewin called the life space.

The health-help-health framework that we have posited provides an organizational framework for examining much of the work that is evolving at the interface of social and clinical psychology. This organizing model contains both person-based processes (e.g., self-related and individual differences issues) and environment-based processes (e.g., interpersonal, diagnosis, and treatment issues).

In the first major section of the Handbook, entitled “Person-Based Processes,” the reader will be given a sample of the new work that is redefining our views of the self, and the role that the self plays in maintaining health; moreover, some of the major individual difference dimensions for conceptualizing the person and health also will be presented in this section.

These person-based or intrapersonal processes may seem ordinary and mundane (and possibly of limited clinical interest), but they nonetheless serve crucial health-maintaining functions. Often psychologists implicitly adopt the medical world’s view of the person as passive; an unfortunate individual who has “taken ill” and must be cured by experts. In the health-help-health model, however, people actively react to problems in living, seeking to maintain or enhance their level of well-being. As Califano (1979, p. viii) suggested in his analysis of health, “You, the individual, can do more for your own health and well-being than any doctor, any hospital, any drug, and exotic medical device.”

In the second major section, entitled “Environment-Based Processes,” the focus will move from the intrapersonal to the interpersonal realm in order to examine external sources for garnering help. Individuals’ success in coping with the large and small problems they invariably encounter on a near-daily basis also depends on their interrelationships with other individuals, including friends, acquaintances, and intimate companions (Brehm, 1984; Hendrick & Hendrick, 1984; Meyrowitz, Burish, & Wallston, 1986; Rogers, 1983, 1984). The first portion of the “Environment-Based Process” will contain chapters dealing with such interpersonal issues. Turning from the analysis of informal, day-to-day health-maintaining interpersonal processes to more formal, professional health-care processes, we will address the identification of problems and treatment approaches. In this latter vein, the second and third subsections of the “Environment-Based Processes” will include chapters describing diagnostic and treatment issues, respectively.

In summary, the health-help-health framework is a heuristic for organizing the ongoing interface research pertaining to the intrapersonal (person-based) and interpersonal (environment-based) processes whereby people obtain help to sustain or change their health.
ON BEING WHERE YOU ALREADY ARE

We are tempted to paint some bold new picture of the interface between social and clinical psychology, and to argue (like Kuhn, 1970) that some sort of major paradigm shift or revolution is taking place. But the nature of the “ah ha” experience for the present editors is somewhat more humble in regard to the present status of the interface. Remember the fable of the elephant and the blind men? A first blind man, putting his arms around the elephant’s thick leg, says, “It must be a tree.” The second, touching the elephant’s vast side, concludes, “It must be a wall.” And a third argues, “No, it is a snake” as he grasps the elephant’s trunk. Indeed, as each successive blind man touches it, he finds a somewhat different “elephant.” Ironically, each protagonist in this story does not realize that he is touching the same thing. In this parable, therefore, we would submit to the reader that the elephant is like the social/clinical interface. Our point is a simple one: There are many professionals who are already doing work at the social/clinical interface, but they do not know it (Snyder, 1988). For such people, reading the following pages may be like visiting rooms in a house that seems strangely familiar.

REFERENCES


