CHAPTER 38

METATHEORETICAL AND EPISTEMOLOGICAL ISSUES

Donelson R. Forsyth
Mark R. Leary

The seeds of an interface between social and clinical psychology were sown in 1921 when the Journal of Abnormal Psychology, founded by Morton Prince in 1906, was transformed into the Journal of Abnormal Psychology and Social Psychology. Prince, along with managing editor Floyd Allport, decided to expand the scope of the journal to incorporate research that bridged the study of interpersonal and abnormal processes. They reasoned that researchers in these fields were interested in many common topics and pointed to the fact that social psychology had already benefited “in a peculiar way” from discoveries in psychopathology. As social psychology came into its own as a behavioral science, subsequent editor Gordon Allport argued that not only did social psychology profit from the study of dysfunctional processes, but that social psychology had much to offer those interested in abnormal behavior. Nearly two decades after Prince’s and Floyd Allport’s call for an integration of social and abnormal/clinical psychology, however, Gordon Allport admitted that few of the articles published in the journal had reflected the connections between social and abnormal psychology they had envisioned (Allport, 1938). Even so, he continued to champion the “marriage of abnormal and social psychology” and called for the “creation of a unified dynamic psychology which, in time, will overarch the divisions of mental science drawn merely in terms of subject matter or in terms of schools of thought” (Allport, 1949, p. 439).

For the next 20 years social and clinical psychology rarely interwined. Indeed, when Goldstein, Heller, and Sechrest surveyed the connections between the two fields in 1966 they found little in the way of social psychology of psychotherapy. Nonetheless, they concluded that extrapolations from social psychological studies of behavior change to therapeutic settings offered a host of new methods for “altering patient behavior” (p. 4). Strong (1968) agreed, calling for psychologists who were interested in client change to draw on social psychological work on attitude change and social influence. But, again, the call went largely unheeded. Nearly a decade later, Brehm (1976) resurrected the idea once again in The Application of Social Psychology to Clinical Practice, urging
others to join in the active application of social psychological principles in clinical realms.

Now, as we move into the 1990s, we see signs that this septuagenarian idea is at last taking hold as increasing numbers of theorists, researchers, and practitioners have begun to advocate the development of links between social psychology and fields that by tradition focus on abnormality and adjustment (Brehm & Smith, 1986; Dorn, 1984; Higgenbotham, West, & Forsyth, 1988; Leary & Maddux, 1987; Leary & Miller, 1986; Maddux, Stoltenberg, & Rosenwein, 1987; Sheras & Worchel, 1979; Snyder & Ford, 1987; Weary & Mirels, 1982). Yet, despite recent progress toward a viable interface between social and clinical psychology (see Leary & Maddux, 1987, for a review), theorists and researchers do not yet agree on a number of central issues pertaining to the social-clinical interface. To some, social psychology is a gold mine of methods for promoting therapeutic change (Harari, 1983), whereas others argue that clinicians should not make use of a theoretical system that views individual action as largely environmentally constrained (Rychlak, 1983; Strong, 1987). Some recommend that social psychologists themselves should get involved in the delivery of therapy (C. Hendrick, 1983), but others caution against their entry into the role of therapist (S. Hendrick, 1983). Some recommend the merging of the fields at the level of service delivery to create a new approach to psychological and somatic treatment (C. Hendrick, 1983; Strickland & Halgin, 1987), but others favor maintaining the current system of clinical training (Winer, 1987). Others wonder if social psychology will provide much useful information given that it relies so heavily on laboratory studies conducted with college students (Garfield, 1979; Gazda & Pistole, 1987), and others rebel at the thought of having to tote the theoretical baggage most social psychologists insist on carrying with them from study to study (Strong, 1987). Some, too, have wondered why anyone would even consider an alliance of clinical psychology with social psychology given the weaknesses in both disciplines (Sarason, 1981, 1987).

In this chapter we explore these and related issues. We recognize that such debates and disagreements are complex and brook no easy solution, but we assume that progress can be achieved by examining the ideas and assumptions that lie at the core of this growing interface between social and clinical psychology. Our approach assumes that links between social psychology and clinical psychology can be forged at a number of different levels, and that the nature of the interface depends directly on the quality and quantity of these linkages. After identifying six levels where possible linkages between social and clinical psychology exist or could be created, we examine two of these possible linkages in greater detail.

**THE NATURE OF AN INTERFACE**

What is an interface? In some usages, an interface is a common ground between independent entities, an area of shared interest that provides a meeting point between otherwise unrelated partners. Alternatively, the term interface has been used to refer to improved communication between two systems, increased coordination between areas that once operated independently, if not at cross-purposes.

Maddux and Stoltenberg (1983) described the interface as a conceptual bridge between social and clinical psychology that makes possible the "use of social-psychological theories (e.g., attribution, attitude change, group process) in increasing our understanding of the development of psychological and behavioral problems and their modification" (p. 289). Similarly, Weary (1987, p. 160) argued that the interface of "social and clinical psychology is based on the notion that systematic attention to social psychological principles is essential to any understanding of the definition, development, maintenance, and modification of maladaptive behaviors." Harvey, Bratt, and Lennox (1987, p. 9) defined the interface in terms of "the study of human problems in living and illness (mental and physical) via an emphasis upon the broad literature of social psychology and social-psychological processes as central explanatory mechanisms."

Such views of social-clinical psychology treat the interface as a unitary, monolithic entity. However, in actuality, these two fields interface on at least six different levels. Specifically, one may speak of the social-clinical interface at an educational, practical, methodological, theoretical, metatheoretical, and epistemological level.

**The Educational Interface**

The strongest and most long-lasting link between the fields can be found in the educational domain. In 1947, the American Psychological As-
sociation's Committee on Training in Clinical Psychology agreed that training

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. (Shakow, 1978, p. 151)

The areas considered to comprise the core in the training of a clinical psychologist have varied over the years, but social psychology has been regarded as a fundamental part of the core. However, this linkage has not been reciprocal. Clinical trainees are expected to study social psychology, but social psychology students are not encouraged to study abnormal behavior, clinical assessment, therapeutic methods, and the like.

The Practical Interface

A second linkage between the fields has occurred at the level of practice. The practical interface involves the potential link between social psychology's research findings and clinicians' therapeutic interventions. In elucidating their concept of "extrapolation," Goldstein et al. (1966) argued that empirical results in nonclinical areas such as social psychology should be used to develop clinical treatments and procedures. Similarly, Harari (1983, p. 176) described social psychology in clinical practice, which "deals with social psychology as a contributing factor in the enhancement of clinical practice." Attributional therapies, one of the most popular applications of social psychology in clinical practice, represent this level of interface, as do other social-psychology-inspired methods such as role-playing, reverse placebo interventions, and some forms of interpersonal skills training. Like the educational interface, the practical interface has traditionally been a one-way street, with clinicians borrowing from social psychology rather than vice versa. Increasingly, however, social psychologists are employing constructs, methods, and findings that originated in clinical practice and research.

The Methodological Interface

Social and clinical psychology also interface at a methodological level. Although social psychology can make no special claim for expertise in research methodology, the field's penchant for sophisticated statistical and methodological practices makes it a valuable resource for applied researchers. Conversely, the unique methodological problems faced by researchers in clinical, counseling, and community settings have stimulated a number of methodological developments. As more social psychologists moved out of the laboratory in the 1980s they took advantage of these methods in their own work (Higgenbotham et al., 1988).

Clinical and social psychologists, too, are united by their interest in the measurement of individual differences, and they can be found side by side building new depression inventories, exploring ways to measure stress, criticizing and improving methods for assessing social skills, and developing coding systems that can be used to structure observations of therapeutic interactions.

The Theoretical Interface

A fourth, less well developed facet of the interface occurs at the level of theory. The theoretical interface involves the integration of facets of clinical and social psychology in constructing conceptual models that are more encompassing than those developed in either field in isolation. Clinical psychology, by tradition, has drawn on personality psychology and behaviorism for its models of abnormality and treatment and as a result the theoretical links between social and clinical have not been fully developed (Rosenzweig, 1949).

Moreover, the linkage is often viewed as a one-way relationship. As noted earlier, Maddux and Stoltenberg (1983) argued for the use of social-psychological theories when studying the origin of dysfunctional behavior and methods of treatment, and Weary (1987, p. 160) proposed that social-psychological principles are critical for understanding "the definition, development, maintenance, and modification of maladaptive behaviors." The chapters of this handbook, however, are evidence that interface theorists and researchers are developing theoretical models that fill the gap between the two disciplines (Leary & Miller, 1986).

The Metatheoretical Interface

Educational, practical, methodological, and theoretical linkages make up the bulk of the explicit cross-disciplinary ties between social and
clinical psychology, but they do not exhaust all the possible linkages. Reaching beyond theory, we find that social and clinical psychologists, qua psychologists, are also linked by certain metatheoretical assumptions. As the philosopher of science Thomas Kuhn argued in his provocative book *The Structure of Scientific Revolutions*, scientists working in a particular field share a set of assumptions about the phenomena they study (Kuhn, 1970). Although these metatheoretical assumptions are rarely discussed explicitly, they provide an undergirding structure that guides the theories formulated and methods used by researchers (Fiske, 1986; Meehl, 1986). The concept of metatheory is relevant here because it suggests that the interface of social and clinical psychology is based not only on shared methodological and theoretical beliefs, but also on implicit beliefs about psychology and about human beings. What is the nature of men and women? Are humans free? Is behavior caused by exogenous or endogenous factors? Are humans governed more by rationality or irrationality? It also suggests that weaknesses in the social-clinical interface may be due in part to differences in the metatheoretical assumptions that characterize social versus clinical psychology. The degree to which social and clinical psychologists agree and disagree on these fundamental questions has direct implications for the viability of an interface between them. We will explore the metatheoretical interface and its implications for social-clinical psychology in greater detail momentarily.

The Epistemological Interface

One last linkage remains to be examined, because how psychologists deal with issues that arise at the level of education, practice, methodology, theory, and metatheory reflects, in many cases, their epistemological assumptions. Put simply, how should our knowledge of human behavior be refined and extended? Should we continue to emulate the methods used in the physical sciences, or should we turn instead to the interpretative disciplines for suggestions and methods of expanding our knowledge? Do theories play an indispensable role in the growth of knowledge or do they blind us to alternative ways of knowing? Should we strive to develop general, lawlike statements about the causes of behavior, or should we focus on single-case, ideographic descriptions? Should theories be judged on their internal consistency and predictive power or on their ability to generate solutions to practical problems? The answers to these questions are tied closely to one's personal and professional philosophy of science, a philosophy that for most psychologists is implicit and unarticulated. We return to the epistemological interface below.

Table 38.1 summarizes the preceding discussion of the various levels of integration between social and clinical psychology. In the sections that follow we will examine these linkages in more detail, focusing on the metatheoretical and epistemological interfaces between the two fields. First, we describe some of the divergent assumptions that structure theorists' analysis of psychological processes and consider how these divergences both hinder and facilitate metatheoretical integration. We then address several epistemological controversies that create divisions between social psychologists and clinical psychologists. The controversies pertain primarily to the nature and conduct of scientific inquiry, the nature of theories and models, and the relationship between empirical evidence and theory in science. We also consider theoretical and practical linkages between the fields, but only briefly because the authors of other chapters in this volume examine these two interface levels in detail. In addition, Smith and Rhodewalt (Chapter 37) discuss methodological linkages and Hendrick and Hendrick (Chapter 39) address the educational/training linkages between social and clinical psychology.

THE METATHEORETICAL INTERFACE

Scientists, whether physicists, psychologists, or chemists, embrace assumptions about their subject matter that are not explicitly acknowledged within the defined domain of their theoretical systems. Scientists, if stripped of their metatheoretical assumptions and reduced to raw empiricists, would be overwhelmed by the countless alternative and correct interpretations of reality. These metatheoretical assumptions are essential because they provide us with an orientation to our subject matter, they identify which questions are worth asking and which ones are not, and they shape the way we see and speak about the world.

Coan (1968), Rosenberg and Gara (1983), and Watson (1967) present a sampling of the divergent metatheoretical assumptions that have characterized various approaches in psychology since the
### Table 38.1. A Six-Level Model of a Comprehensive Interface Between Social Psychology and Clinical Psychology

<table>
<thead>
<tr>
<th>LEVEL OF INTERFACE</th>
<th>EXAMPLE ISSUES</th>
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<tbody>
<tr>
<td>Educational</td>
<td>What educational experiences should be included in the training of therapists? Should the training of academic social psychologists include work in clinical settings? What areas define basic studies in psychology?</td>
</tr>
<tr>
<td>Practical</td>
<td>How can the utility of group psychotherapies be increased? Why do paradoxical therapies work? How can we prevent premature termination of treatment? How does the client-therapist match influence treatment outcome?</td>
</tr>
<tr>
<td>Methodological</td>
<td>How can the results of multiple independent studies be combined statistically? How can the placebo effects of a treatment be distinguished from the treatment-specific effects? How can the key the qualities of one’s social support network be assessed?</td>
</tr>
<tr>
<td>Theoretical</td>
<td>What interpersonal and intrapersonal factors work to promote adjustment and what factors contribute to dysfunction? How do individuals cope with stressful environmental events? What factors are involved with recovery from psychological and physical illness?</td>
</tr>
<tr>
<td>Metatheoretical</td>
<td>What is the essential nature of the human being? Is behavior caused by exogenous or endogenous factors? Are humans governed more by rationality or irrationality? Is the human species unique?</td>
</tr>
<tr>
<td>Epistemological</td>
<td>How should human thought, feeling, and emotion be studied? What is the relationship between conceptual understanding and empirical findings? Is psychology a science, in the same sense that physics is a science? Do laws of human behavior exist?</td>
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Field's inception. Psychologists have debated such metatheoretical issues as

- Should we be concerned with unconscious processes, or focus only on observable behavior?
- Is behavior caused by forces present in the immediate external environment, or historical factors whose force is still felt in the distant future?
- Can psychological processes be broken down into specific elements, or should we take a holistic approach that avoids analysis?

Our answers to these questions summarize our beliefs about the prime causes of behavior and the nature of human beings.

Watson (1967) has noted that these bipolar themes, which he called “prescriptions,” serve to orient researchers and theorists when they conceptualize problems within psychology. His analysis, extended to the social-clinical interface, suggests that if social and clinical psychologists share metatheoretical assumptions then they would also be united in their theoretical and methodological orientations. If, however, the two fields embrace disparate metatheories, then disunity is to be expected. Here we compare and contrast three assumptions that, although rarely explicitly stated, constitute basic differences between much of contemporary social and clinical psychology.

**Sociogenicism-Psychogenicism**

In a tradition dating back to the field’s founding, social psychologists focus first on exogenous causes of behavior before turning their attention to endogenous causes (Snyder & Forsyth, Chapter 1). Asked why an individual self-aggrandizes, acts altruistically, or engages in aberrant actions, the social psychologist's first inclination is to examine the social forces in the situation. Intrapersonal processes are not ignored, but they are typically viewed as dependent variables or as mediators of external causes. Social psychological models tend to stress environmental determinism over biological determinism, situationism over personologism, and sociogenicism over psychogenicism.

An equally long tradition, which has roots in Freud's psychodynamic theory, prompts many clinicians to focus on the internal, psychogenic determinants of behavior. With behaviorists providing a notable exception, the theorists who provided the foundations for much contemporary clinical conceptualization and intervention offered models that included reference to the structure of personality, dynamic intrapsychic mechanisms, and the relationships between the individual's particular qualities and his or her behavior. Adler, Freud, Jung, Horney, Maslow, Murray, and others were generalists, but at the core their
theories assumed that personality, needs, motivations and other psychogenic mechanisms play a pivotal role in adjustment and dysfunction. The psychogenic orientation was summarized by Urban (1983, p. 163), who argued strongly that when psychologists look for causes outside of the individual they "deny and distort the essential quality of human existence. Everything of significance with regard to this entire process occurs within the inner or subjective experience of the individual." Psychogenicism is also compatible with general endogenism, in which behaviors are attributed to a host of internal processes such as genetic factors, past events, and biological processes.

These divergent meta-assumptions regarding sociogenicism and psychogenicism influence social psychologists' and clinical practitioners' analyses of human behavior at a variety of levels. Whereas psychodynamic concepts have trouble taking hold in social psychology (Hall & Lindzey, 1969), they are the cornerstone of much current thinking in clinical psychology (Blatt & Lerner, 1983; Robbins, 1989). Aside from the content of psychoanalytic theory per se, its psychogenic emphasis is inconsistent with most social psychologists' metatheoretical bent toward sociogenicism.

Much of clinical psychology also stresses the causal importance of the individual's past and future, suggesting that previous experiences determine current level of adjustment in tandem with striving for future outcomes. Because these factors must be represented within the individual, social psychology tends to ignore them, choosing instead to focus on contemporaneous causes present in the immediate setting. The result: Social psychologists view the person in mechanistic, static, nontelic ways, whereas clinical psychologists highlight motivational, goal-seeking, and dynamic processes in their analyses.

These metatheoretical differences lead social and clinical psychology to take quite different tacks when addressing the same processes. In the study of attraction, for example, social psychologists spent decades examining the impact of situationally specific factors—similarity in expressed attitudes, propinquity, approval, and so on—on liking. When clinical psychologists began to study the nature of the therapeutic relationship—a topic that also involves interpersonal attraction—they focused not on contextual factors, but on the match between the unique personal characteristics of the two individuals involved (Beutler, Clarkin, Crago, & Bergen, Chapter 35).

A similar difference unfolded as social and clinical psychologists explored attributional processes. Social psychologists, stimulated by Heider's (1958) provocative theoretical notions, erected sophisticated theoretical models about how people identify causes of their and others' actions. These models specified the dimensionality of attribution thought and the basic processes involved in causal thinking, but theories assumed everyone made attributions and that these attributions were affected by certain aspects of the situation. Clinical psychologists, in contrast, were drawn to the study of attributions by perplexing experimental findings pertaining to the effects of uncontrollable circumstances on motivation and by conflicting symptoms reported by depressed individuals. Clinical models also were based on Heider's work, but in this case the focus was on individual differences in attributional tendencies. The core idea was that certain styles of attribution are healthy, whereas others are maladaptive (Peterson, 1985).

Although experimental social psychologists have long been interested in personal factors such as attitudes and values, historically the field has been ambivalent about the importance of personality variables. This stance, however, is changing. Many social psychologists are now interested in how individual differences moderate people's reactions to various situations. Much of this work is occurring in the context of studying interactionistic models that strive to understand how dispositional and situational factors combine to influence behavior.

Indeed, much current work that is regarded as social-clinical in focus, even that conducted by scholars who identify themselves as social psychologists, involves not extrapolations of experimental social psychology, but rather the study of personality variables in the development and treatment of dysfunctional behavior. Recent clinically relevant research on topics such as attributional styles, self-esteem maintenance, social anxiety, loneliness, stress, sex roles, and the like involves an emphasis on individual differences and personality processes.

Put differently, the growth of the social-clinical interface has been stimulated by growth of the social-personality interface. Bliss (1984), for example, noted that the theoretical assumptions and methodological tools of social and personality psychology are being used by the other with increasing frequency (see also Baron & Boudreau,
1987; Ryff, 1987). In many cases researchers have reached beyond the individual difference definition or situational definition of a variable to define the construct in terms that apply at both levels. Self-attention, for example, has been studied by examining the reactions of individuals who vary in dispositional self-consciousness and by manipulating subjects' level of self-awareness in the research setting. Blass also notes that social psychologists have extended their long-standing interest in the relationship between attitudes and behaviors to a more general interest in the relationship between personal factors (personality, traits, attitudes, attributions) and action. This growing recognition of the interaction of social and personality factors by social psychologists complements the movement toward interactionism in clinical psychology that dates back to the 1970s. In response to Mischel's (1968) challenges, clinical theorists continue to shift from a pure trait view of personality toward an interactional perspective (Magnusson & Endler, 1977; Snyder & Ickes, 1985). Interpersonal theory, too, offers an alternative to traditional psychogenicism. This approach, as summarized by Anchin and Kiesler's (1982) Handbook of Interpersonal Psychotherapy, affirms Sullivan's (1950, p. 92) claim that "the general science of psychiatry seems to me to cover much the same field as that which is studied by social psychology, because scientific psychiatry has to be defined as the study of interpersonal relations" (Kiesler, Chapter 22; Strong, Chapter 27). Sullivan's ideas concerning the interpersonal bases of both abnormal and normal behavior are being extended actively by researchers, who are finding that maladaptive behaviors can be both defined and treated interpersonal. Still, given the intrapsychic bent of many clinicians, interpersonal theory is rarely put into practice. As Carson explained, "one of the more extraordinary characteristics of interpersonal theory is the extent to which it is ignored, particularly among writers who purport to survey the field of personality theory" (1983, pp. 148-149).

Despite movement toward an integration of sociogenicism and psychogenicism, some have questioned whether these perspectives are, in fact, reconcilable. For example, Berglas (1988) argued that these two paradigms are so different that the results that they yield are incommensurate with one another, and Rychlak (1983) expressed doubts about the reconciliation of these views. Furthermore, some have condemned social psychologists' interest in intrapersonal variables altogether (e.g., Carlson, 1984).

In sum, despite the traditional inward and outward focus of clinical and social psychology, recent developments suggest a gradual weakening of this posture and growing openness to the alternative view. The acceptance of social causes as primary is fundamental in social psychology, but single-minded sociogenicism constrains the study of behavior, whether normal or abnormal. Similarly, clinical psychology's psychogenicism forces theorists, researchers, and clinicians to rely too heavily on traditional personality theories, traits, and dispositional variables. The limitations of such myopia were vividly lamented by Sarason (1981):

Built into psychology, part of its world view, is the polarity man and society. Call it a polarity or a dichotomy or even a distinction, it makes it easy for psychology to focus on one and ignore the other, to avoid dealing with the possibility that the distinction is arbitrary and misleading, that it does violence to the fact that from the moment of birth the individual organism is a social organism, that social means embeddedness in patterned relationships that are but a part of an array of such relationships rooted, among other things, in a social history and a distinctive physical environment. (p. 175)

**Humanism-Egoism**

The story is well known in psychology circles. Dismayed by the narrow views of human beings proffered by Freudians and behaviorists, a clique of influential theorists including Maslow (1971), Rogers (1942), and Fromm (1955) called for a more humanistic orientation. Their arguments went unheeded within much of academic psychology, but in time many psychologists engaged in clinical practice came to embrace many of the assumptions of humanistic psychology: our ability to rise above limiting situational constraints; to make sense of ourselves and our social world; to imagine alternative futures and undertake steps to increase the likelihood that the ones we favor will occur; and to identify what gives our lives meaning. Urban (1983) summarized this humanistic view when he wrote

Humans have the capacity to transcend the immediacy of the present and to envision alternate states and possibilities; this provides the opportunity for one to invest meaning into one's existence, specifically to formulate intention, sense, purpose, and significance into the pursuit of
one's life. To be authentically human is to become increasingly open to experience, to accept the inherent freedom associated with one's fate, to assume fully the responsibility for developing and constantly refashioning one's identity, one's personal commitments, and one's life. (p. 163)

Few would argue that social psychology is a humanistic discipline. Although not radically behaviorist, most social psychologists assume that the minimax principle dictates most of our actions. Our choices, our relationships, and even our apparently altruistic actions can be traced to our desire to maximize our positive outcomes while minimizing our costs. Although the cognitive movement in social psychology led researchers to pay attention to the ways in which people make sense of the world and themselves, the person is still viewed as a relatively passive information-processor who takes shortcuts. Also, even though social psychologists acknowledge the existential strivings of human beings, most assume that these strivings are muted by our unremitting egoism. The individual views the world from his or her own perspective, and the biases inherent in this limited viewpoint are never wholly escaped.

This assumption, although occasionally challenged, suggests that the self is a primary psychological mechanism. However, the social psychological notion of the self bears little resemblance to the self described by humanistic psychologists. Most social psychologists view the drive for self-promotion as stronger than the drive for other-promotion. Human beings are so fundamentally egocentric that social psychologists are skeptical about the inherent goodness of individuals, to the point that moral behaviors such as altruism are viewed as impossible (cf. Campbell & Specht, 1985; Kelley & Thibaut, 1985; Wispe, 1985). In brief, social psychologists tend to share the metatheoretical assumption that people are, on the whole, egoistic and self-serving.

Social psychology's reverence for studies that demonstrate the powerful impact of external factors on the individual illustrate the antihumanistic flavor of the field. Asch's (1955) studies of conformity, Milgram's (1974) classic studies of obedience, the countless studies of people competing in the Prisoners' Dilemma, and Latané and Darley's (1970) analysis of bystander apathy all affirm the image of the human being as easily swayed by situation concerns, willing to violate personal values, and hungry for self-enhancement. Studies of attitude change following counterattitudinal beh-

avior, for example, indicate that most individuals, with very little situational pressure, willingly misrepresent their actual attitudes and beliefs to others. Although the causes and consequences of this counterattitudinal advocacy are still debated, a self-presentational explanation suggests that individuals lie in such settings so that they can project an image of rationality and consistency. They realize that what they are saying is not true, but they state certain attitudes to present a socially acceptable impression to the experimenter and others (Schlenker, Forsyth, Leary, & Miller, 1980). Thus, even instances of apparent consistency and rationality may be a facade.

Despite social psychology's long disdain for things humanistic, recently researchers have begun exploring the waters beyond this meta-theoretical assumption. Self theorists, for example, are beginning to recognize that the self system does more than simply maintain and promote oneself (Epstein, 1985; Hales, 1985). Perhaps the most boundary-stretching of these new views is Solomon, Greenberg, and Pyszczynski's (Chapter 2) terror-management theory, which argues that the self-serving attributional bias that so thrilled social psychologists who were interested in egocentric biases is caused by the existential terror we experience when we come face to face with the realization that death is inescapable.

Studies of helping behavior provide yet another example of changes in social psychologists' view of the human being. For years this topic has been dominated by models that argue that people help others only to maximize their own personal outcomes. Recently, however, researchers in social psychology have begun to search for nonegoistic, other-serving helping. Batson, for example, offered evidence of two different classes of helping—egoistic helping that results in positive feelings for the helper and empathic helping that is motivated by an altruistic desire to reduce the distress of the person in need. Although questions remain, preliminary findings suggest that unlike the egoistic helper, the empathic, altruistic helper is truly other-serving (Batson & Coke, 1981; Batson, Duncan, Ackerman, Buckley, & Birch, 1981).

These advances argue in favor of an expanded model of human beings that reconciles their egoistic and humanistic capabilities. A social psychology based completely on egoism and selfishness as primary social motives is a restricted social psychology (Vitz, 1977, 1983; Wallach & Wallach, 1983). Social psychology strives to provide a
cross-cultural view of human behavior, but clearly
not all cultures prize selfishness as much as the
Western world. As Hogan and Sloan (1985) asked,
is it just coincidence that a social psychology
rooted in a culture that praises independence and
self-seeking strivings implicitly assumes that indi-
viduals are egoistically motivated? Similarly, a
purely humanistic psychology has difficulties
coping with nonconscious motivations, with irra-
tional, aggressive behavior, and with the tremen-
dous impact of society on the human individual.
These flaws, however, are not fundamental ones.
Therefore, rather than rejecting either view and
replacing it with another, an integrative approach
argues for a synthesis that retains the strengths of
each while avoiding the weaknesses of each.

Rationality-Nonrationality

Social psychological theorizing, in many re-
gards, highlights humans’ rationality. People are
viewed as processors of information who con-
stantly seek data about themselves and others,
then base their behavior on the available infor-
mation. Of course, the available information is
sometimes inaccurate and/or distorted (often by
the egoistic biases discussed above). Even so, peo-
ple are viewed as conscious thinkers who, despite
their episodes of irrationality, do their best to pro-
cess information. Social psychologists admit that
reinforcements play a major role in shaping be-
havior and that nonconsciousness processes may
influence thought and feeling, but the social psy-
chologist adds that cognitive processes, including
goal-seeking and information-processing systems,
also must be considered. In brief, the social psy-
chologist tends to emphasize conscious thought.

Clinical psychology, in contrast, considers the
less rational side of human existence. The clini-
cian deals with individuals whose cognitive, moti-
vation, and emotional rigidities are overriding
their ability to adapt to situational influences.
Whereas the rational person processes information
and responds accordingly, the abnormal indi-
vidual reacts automatically, inappropriately, and
consistently across settings. Their actions, too, are
caused by nonconscious factors that are only
glimpsed by the individual, if not outside of con-
scious awareness entirely. Viewed from this per-
spective, behavior and emotion are seen to be
products of nonconscious motives that spring
from unseen intrapsychic wells. In many models,
the individual cannot be rational even under the
best of circumstances because most of the forces
that guide behavior remain largely hidden. In
brief, clinical models tend to regard conscious
thought as relatively unimportant.

Even when thoughts are in awareness, most
classic theories of dysfunction stress the role of
irrational thought in behavioral and emotional
problems, if not in the human condition. Psycho-
analytic approaches, for example, focus on iden-
ifying and correcting outdated and unrealistic
views of oneself and others. Cognitive-behavioral
approaches often stress the effects of maladaptive
cognitions on dysfunctional behavior and emo-
tion. Approaches based on rational-emotive ther-
apy are perhaps prototypical in this respect be-
because they try to demonstrate the irrational and
self-defeating nature of the client’s belief system.

Of course, the human being portrayed by both
the social psychological and clinical psychological
perspectives is but a caricature. People are, at
times, both rational and irrational, and their be-
havior is controlled by factors of which they both
are and are not aware. Thus, again, we see that a
metatheoretical integration of social and clinical
psychology provides a broader, more realistic view
of human behavior than does either alone.

Metatheory at the Interface

We have examined three issues that sit squarely
in the center of the metatheoretical interface of
social and clinical psychology. On all three, tradi-
tional social and clinical psychology divaricate,
with social psychology stressing external causes,
the egoism of human beings, and our rationality,
and clinical psychology stressing internal causes,
humanism, and nonrational processes, including
emotions and unconscious motivations.

Fortunately, these orienting prescriptions are
not necessarily the binding (or biasing) world-
defining postulates of a Kuhnian paradigm. If ac-
cepted as paradigmatic givens, then the psycholo-
gist could not escape their constraints to view
behavior from a different perspective. The hu-
manist could not step back and look at human
actions as motivated by biological urges that are
common in many species. The behaviorist could
not admit that, in some cases, individuals are mo-
tivated by existential strivings and personally sali-
ent goals. The ecological psychologists could not
recognize that different individuals react uniquely
to the same behavior setting. Rather, these
assumptions provide the underlying defining
structure of theory of psychology and ensure a constant dialectical interplay among opposing theoretical camps. These differences between social and clinical psychology reach down to the theoretical core of these disciplines, and to their interface as well. The social-clinical interface offers theorists the means of achieving greater understanding of human behavior through the synthesis of two disciplines that embrace opposing goals, methods, and philosophies.

THE EPISTEMOLOGICAL INTERFACE

For centuries psychology was an integral part of philosophy. When questions about the nature of the mind, the relationship between mental events and physiological processes, and the innate propensities of the human being arose, they were settled through philosophical discussion. This tradition changed radically, however, when psychology broke from philosophy to strike out as a science. Rather than generating knowledge only through insight and discourse, these new psychologists advocated supplementing conceptualization with observation and analysis of objective evidence. Rather than rely on debate to settle disagreements, psychologists turned to data as the final arbiter. And rather than rely on folk wisdom and common sense when explaining the nature of thought, feeling, and action, psychologists spun their own theories and tested these theories empirically.

As social and clinical psychology emerged as subfields within psychology, both of these subfields adopted—at least implicitly—these overarching epistemological assumptions of the psychologist qua scientist (Forsyth & Strong, 1986). Their unique interests and objectives, however, took them in somewhat different directions. Researchers (both social and clinical psychologists alike) sought to identify general tendencies in human behavior and to construct logically coherent models that would account for these tendencies. Practicing clinicians, in contrast, confronted a veritable sea of unique human beings seeking to overcome personal limitations and psychological dysfunction. Rather than searching for lawlike generalities, clinicians required heuristic guidelines that offered insights on a person-by-person basis.

The bifurcation of psychology into two opposing camps split on epistemological issues has been decried by many (Harcum, 1988; Kimble, 1984; Koch, 1981; O'Hara, 1986; Rogers, 1986; Staats, 1981), but Chein's (1966) distinction between scientific and clinicalistic psychology captures the essence of the issues. Chein argued that small differences between research-oriented psychologists and applications-oriented psychologists became exaggerated over time, and eventually resulted in two different subcultures within psychology: scientism and clinicalism.

Scientism, which is the doctrine of many social psychologists (and academic clinical psychologists as well), advocates the strict application of the hypothetico-deductive method of science, including theory construction, experimentation, quantitative methods, prediction, and the use of appropriate terminology. Wrote Chein:

The most extreme expressions of scientism involve doctrinaire views on the nature of science and on proper rules of scientific conduct and expression. . . . The scientist is given to respectable language, respectability being far more important in practice than the rationalizing value of precision. Scientism [also] tends to seize upon a particular set of primitive terms and propositions (typically, but not necessarily, drawn from physics, chemistry, or psychology) and to assume it to be optimal and sufficient. The particular set may vary from one scientist to another, but both operate in terms of such sets, tolerate one another's sets, and dismiss anything not included in or deducible from the union of sets selected by themselves and fellow scientists as unreal or inconsequential. (pp. 337–338)

Chein (p. 341) suggested that the basic theme of scientism is summarized by the question, “How can knowledge grow if we do not get started on knowing at least something definitively?”

Clinicalism, in contrast, is the doctrine of many, but by no means all that of practicing clinicians. According to Chein (1966, p. 338) this “approach to knowledge” rejects scientism, and replaces it with personal comprehension. From Chein:

The clinicalist tends to be suspicious of any fixed scheme of classification, preferring to pick the concepts that best fit the case, and hence to select from a nonsystematic array of concepts. . . . He may espouse a particular theory, but only as a helpful guide to observation. . . . Controlled observation is, for him, constituted of intensive and extensive probing and feedback from test interventions. . . . Although he may express some generalization, he does not intend it to be taken literally and is apt to feel badgered when one persists in trying to hold him to it. . . . The clinicalist does not seek to discover, formulate, or
prove any general laws. . . . He assumes that determinants—in inner and outer—are in continual flux, in ever changing configurations of varying subsets, and doubts the discoverability of laws. . . . Evidence of the predictability of behavior in controlled laboratory conditions evokes a suspicion that laboratory situations are so abnormal that no generalizations from them are warranted. (p. 338)

Chein (p. 341) suggested that the basic theme of clinicalism is summarized by the question, "How can knowledge grow if we keep blocking growth by prematurely freezing categories and the dimensions of inquiry into functional relationships, thereby losing contact with the primary data of all knowledge, the manifold particularities?" (p. 341).

The implications of Chein's analysis are powerful and far-reaching. If psychologists adopt such differing epistemologies, then how can the interface hope to bridge the gap between them? Keeping in mind that the diversity of opinion and outlook within each of these disciplines makes sweeping statements about these differences oversimplifications, several aspects of their epistemological outlooks are examined below.

**Positivism**

In the first half of this century, logical positivists were kept busy trying to describe how science worked. Mach (1897/1914), for example, argued that theories are summaries of empirically verifiable relationships among variables. Because it only summarizes the data, a good theory should not go beyond these data, he argued. If it does, it becomes metaphysical. The logical positivists also stressed the power of deduction as the most adequate means of achieving an understanding of the regularities underlying observed phenomena. For Popper (1959, p. 59), the "explanation of an event means to deduce a statement which describes it, using as premises of the deduction one or more universal laws, together with certain singular statements, the initial condition." In like fashion, Hempel and Oppenheim's (1948) deductive-nomological model argued for the axiomatization of theory by forming general lawlike statements, the specification of antecedent-limiting conditions, deriving hypotheses from theories, operationalizing definitions, and the potential disconfirmability of theoretical systems (Hempel, 1966).

The work of such philosophers as Kuhn (1970), Feyerabend (1970), Achinstein (1968), and Hanson (1958) did much to temper the strict arguments offered by the logical positivists. Although their viewpoints varied, all agreed that no science—not physics, not chemistry, not psychology—works in the way described by logical positivists. Newton did not deduce his laws, Einstein did not rely solely on data to develop his theory of relativity, and the rejection of Bohr's theory of the atom depended more on logical argument than on empirical findings. Moreover, sciences come in many variations, and it is doubtful that any single philosophy describes the methods and foundations of the growth of scientific knowledge. As D'Andrade (1986) noted, sciences such as physics, chemistry, and astronomy deal with aspects of the universe that are relatively unchanging and strive to make generalizations that will hold across diverse times and places. Biologists, geologists, and some social scientists, in contrast, examine aspects of the world that are more transient and situationally specific. Biologists, for example, recognize that the organic processes they study occur here on the planet Earth, but might not occur in other environments. These disciplines do not conform to the dictates of Hempel's deductive-nomological model, yet they are still scientific.

**Postpositivism**

Many contemporary social and clinical psychologists recognize the limitations of logical positivism as a model of how science works, but they accept a modified version of positivism, often termed postpositivism. This view maintains that science, as an epistemological system, relies on methods that are different from alternative epistemologies. More than other approaches to gaining knowledge, science advocates the long-term goal of increasing and systematizing our knowledge about the subject matter. It requires relating observations back to theoretical constructs that provide the framework for interpreting data and generating predictions. In addition, science insists that the test of theory be based on objective, empirical methods rather than on logical claims, subjective feelings, or authorities' opinions. Science also involves a striving for consensus among members of the discipline concerning acceptable and unacceptable explanations of empirical observations. Psychological studies, if they are to be scientific, must remain within these boundaries. Hypotheses offered must be empirically testable,
using methods that other scientists accept as adequate. Although values undoubtedly play a role in determining which topics are investigated and the researcher's bias for one interpretation over another, values should have no impact on the data collection procedures or statistical analyses.

Constructivism

Other theorists, however, believe that even positivism provides a limited view of how science works and argue in favor of an alternative philosophy of science. These various viewpoints include socioculturalism (Gergen, 1978, 1984), hermeneutics (Alexander, 1988), dialectics (Rychlik, 1968), ethnography (Garfinkel, 1967), ethnomethodology (Harre & Secord, 1972), realism (Manicas & Secord, 1983), and semiotics (D'Andrade, 1986). Although these alternatives differ from one another in a variety of ways, most argue that social scientists should stop trying to emulate an approach that is suited for the natural sciences. Rather, they suggest that social scientists must develop methods that take into full account the reflexive, interpretive, constructivist nature of all human activity. Rather than assuming facts exist, that observation is a neutral process, that causality is linear, and that individual action can be examined in mechanistic terms, these viewpoints champion the in-depth study of behavior as it occurs in ongoing settings using ethnography and detailed interviewing, the intimate involvement of the researcher in the data collection processes, and close scrutiny of the participants' construction of the situation.

Constructivist philosophies of science do not dominate clinical theory or clinical practice, but these approaches are quite consistent with the idiographic and phenomenological-humanistic traditions that imbue much of clinical psychology. Gordon Allport's distinction between idiographic and nomothetic approaches to psychological issues is still relevant, still debated, and still unresolved (Brooks & Johnson, 1978; Dukes, 1965; Holt, 1962; Marceill, 1977). Allport (1937), in a prophetic statement, argued

Humanistic psychologists also reject the mechanistic, biological models of human behavior in favor of a view that highlights our sense-making capabilities (Frankl, 1962). Phenomenologists, including Rogers (1942) and Snygg and Coombs (1949), argued that behavior cannot be understood until we discover the meaning that the individual attaches to it. Existentialists, when they emphasize awareness, human choice and freedom, and the fragility and plasticity of the human experience, are espousing a view that is well suited to a constructivist epistemology.

Constructivism also minimizes the gulf between the clinical researcher and the clinical practitioner. As Higgenbotham, West, and Forsyth (1988) noted, clinical practice requires tremendous amounts of interpretive activity. Clinicians must employ an interpretive corpus drawn from a socially sanctioned system of reality (e.g., psychodynamic theory, cognitive-behavioral theory, or whatever), then construct their client's condition and their subjective interpretation of the problem. Through interpretive work the clinician identifies (or, in the language of constructivism, "makes") behavioral and psychological particulars, abstracts the complex totality of the distressed client, interprets the abstracted data, and constructs a clinical reality that then becomes the object of a therapeutic endeavor. Often, too, the clinician must translate across two systems of meaning—the view of clinical psychology and the view of the client (e.g., Good & Good, 1982; Kleinman, 1986; Labov & Fanshel, 1977). Although a positivist would argue that the practitioner is being non-scientific when engaged in such a highly interpretative process, the constructivist would argue that the reality-building, data-making work of the clinician is no different from the theory-building, data-collection work of the researcher.

The Dialectical Epistemology of the Interface

Most psychologists embrace the dictates of a positivistic philosophy of science that argues scientists must generate lawlike statements that can be tested via research. Some, however, advocate constructivism, for they feel that if one is to understand an individual, then theory and research must be ideographic rather than nomothetic. The positivist argues that data are not particularly meaningful unless embedded in a theoretical context, whereas the constructivist prefers to use
theories as heuristic guides rather than as con-
straining frameworks. Given that positivists and
constructivists seek the growth of knowledge via
different, and immediately incompatible, routes,
which route will be chosen by researchers seeking
to link social and clinical psychology?

If history and tradition provide an indication,
then positivism will probably hold sway over con-
structivism, at least in academic circles (O'Hara,
1986; Kimble, 1984). If, however, researchers re-
main both rational and flexible, then a choice may
not be necessary. Although the logical positivists
argued for a view of science founded an unidirec-
tional causality, explanation of the whole through
analysis of the component parts, and an accretive
research process that more and more accurately
describes the world, progress in science often re-
results from a dialectical process involving thesis,
Rather than staunchly defending a viewpoint
against attack, the dialectician searches for the
means to reconcile multiple, yet inconsistent, in-
terpretations of reality. Such an approach requires
taking the best from positivism and the best from
constructivism and synthesizing them in a dialect-
tical philosophy of science.

Chein (1966) herself favors this synthesis as the
solution to the schism between scientism and clini-
calism. She wrote:

Let there be free competition of ideas, of metho-
dologies, and even of doctrinaire views. But let us
also beware of permitting, if only by default, ex-
tremists to curtail the competition or to build
walls that block channels of free communication.

. . . Let us also recognize the need to expose our
students to both subcultures and to meaningful
approach to integrating them. Our students are
the ones who will be carrying psychology for-
ward, and we can do them no greater service than
to expand their epistemological horizons.

CONCLUSIONS AND IMPLICATIONS

Is an interface between social and clinical psy-
chology possible? The history of psychology gives
cause for optimism, for the idea of achieving
greater understanding of human behavior by link-
ing together the subfields of psychology is not a new one.
In the late 1940s several regional and national con-
ferences were held to discuss the then radical idea
of integrating clinical psychology and personality
psychology. At the end of World War II the role
of the clinical psychologist expanded to include
treatment, but these treatments often lacked a
theoretical foundation. As Snyder (1949) com-
plained,

I believe that it is time for us to face reality,
and to admit that in the field of psychotherapy
there is very little basic theoretical underlying
structure that is at all convincing. Many clinical
psychologists, as a matter of fact, seem not to
recognize the need of an integrated theory of beh-
vior. . . . (p. 22)

To deal with this problem, both therapists and
researchers recommended the integration of per-
sonality theory with clinical work. Rosenzweig,
who presided at two of the conferences (1949, p.
5), called for an integration of academic psychol-
ogy and clinical psychology:

To solve the implied problem it would seem that
the clinical worker has need to recognize the the-
oretical implications of his tools and his con-
cepts; the academic psychologist may reasonably
be expected to reorient some of his efforts toward
the study of the total individual. . . . By fos-
tering all possible relationships between person-
ality, including social and abnormal psychology,
and the-clinical study of the individual, the ob-
jective could be realistically implemented. (p. 6)

Discussants varied, however, in their optimism
concerning such integration, and in their remarks
they identified a number of problems that would
have to be surmounted before such a united effort
would be successful. First, many wondered about
the tremendous gap between the academic person-
ality psychologist's view of the person and the
view adopted by most clinicians. Championing an
idiographic approach, Rosenzweig (1949, p. 5)
doubted that "one can deduce from general laws
of segmental behavior the structure and function
of individuals. If one is to learn about individuals
it seems probable that one will need to begin with
them, in all their intricacies, as the units of obser-
vation and conceptualizations." Because academi-
cians preferred a nomothetic approach to person-
ality, the clinicians doubted that much could be
achieved through an integration.

Second, Rosenzweig questioned the content of
personality theory itself when he argued that clini-
cal psychology cannot be applied psychology, be-
cause no "basic" science foundation exists: "Since
historically there is no clear relationship of depen-
dence between academic psychology and the prac-
tical work of the clinician, considerable doubt ex-
ists as to just what is being applied" (p. 5). Angyal (1941) made the same point when he said that psychiatry is the application of a basic science that does not exist.

Third, the discussants wondered how the theories themselves would translate in clinical practice. As Rosenzweig noted,

...theories of the academic psychologist and the practices of the clinical psychologist have for the most part developed independent of one another. On occasion, to be sure, the one field has fertilized the other and there has been a fruitful consummation... Many such instances, however, would be difficult to find. (p. 4)

Fifty years later these doubts sound familiar, but they are the doubts we express about the unity of clinical and social psychology. The problems that Rosenzweig and the other discussants identified were gradually overcome, and the interface of personality theory and clinical practice has largely been achieved. Likewise, the problems that confront social-clinical integrationists are sizable, but not insurmountable.

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