CHAPTER 40

THE INTERFACE TOWARD THE YEAR 2000

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THE HEALTH-HELP-HEALTH FRAMEWORK REVISITED

In Roman mythology Janus was a powerful god; only Jupiter outranked him in prestige and authority. The Romans believed it was Janus who opened and closed the gates of heaven each morning and evening, and they often portrayed him as a man with two faces; one facing east and one facing west. He was the god of all beginnings and all endings, and the Romans felt doorways and gateways symbolized Janus’s power. Today, to be “Janus-faced” implies deceit, but to the Romans the two faces symbolized Janus’s ability to see in two directions at once—into both the past and the future and at the good and the bad.

In this chapter we look at the interface of social and clinical psychology as Janus would. First, we look back by reviewing the foundations of the interface as explicated in the preceding chapters. Using the health-help-health framework as an organizing heuristic, we briefly consider both person-based processes such as self-maintenance systems and personality processes, as well as environment-based processes such as interpersonal relations, diagnosis, and treatment. Second, we also look forward into the future to prophesy what will happen to the interface in coming years. The interface holds considerable promise for advancing our understanding of human adjustment and dysfunction, but its viability depends on its success in the face of challenges and confrontations that lie ahead. In both our look back and look forward, we draw on the insights of a number of individuals who have played instrumental roles in social and clinical spheres. Their commentaries are interspersed throughout this final chapter.

Person-Based Processes

The health-help-health framework assumes that health, which is broadly defined as that psychological and physical state of well-being that the individual is motivated to sustain or change, is the product of both the person-based and environment-based processes. Looking first at person-based processes, past research and the preceding
chapters have focused on the two major constellations of concern: (a) the self and its dynamic processes and (b) the measurement and meaning of individual differences (Snyder, 1988). The lessons learned by investigators toiling in both of these fields are considered below.

**Self-Related Issues.**

It has long been argued that the self is a cognitive structure by which people organize information about who and what they are. William James highlighted the social foundations of the self when he wrote that if people “acted as if we were nonexisting things, a kind of rage and impotent despair would ere long well up in us, from which the cruelest bodily tortures would be a relief” (1890, p. 293). Now, a century later, researchers have revived this perspective by advocating the importance of self-schemas and self-theories as structures for knowing oneself (Greenwald & Pratkanis, 1984; Kihlstrom & Cantor, 1984; Markus & Wurf, 1987).

This reawakened interest in the nature of the self has stimulated the study of self-processes: the causal and mediational impact of the self has stimulated the study of self-processes: the causal and mediational impact of the self on thought, emotion, and action (Markus & Sentis, 1982; Markus & Wurf, 1987; Neisser, 1976; Snyder, 1989). As Markus and Wurf (1987) wrote,

The unifying premise of the last decade’s research on the self is that the self-concept does not just reflect on-going behavior but instead mediates and regulates this behavior. In this sense the self-concept has been viewed as dynamic—as active, forceful, and capable of change. It interprets and organizes self-relevant actions and experiences; it has motivational consequences, providing the incentives, standards, plans, rules, and scripts for behavior; and it adjusts in response to challenges from the social environment. (pp. 299–300)

This handbook’s chapters on the self generally share this emerging “hot” perspective on the self. In other words, the processes involving the self, in many instances, are conceptualized as being intimately tied to particular types of appraisal, attention, and motives. In turn, these appraisal, attentional, and motivational processes that operate in the various self systems appear to have health-related sequelae. Indeed, a common theme is that the self processes enable us to better understand the ways that people may sustain positive health; conversely, these same self processes give us clues about poor health.

Such theories and supporting findings may provide an answer to a question that occasionally is asked by graduate students who are beginning their practicum work. The question is, “What use is it to know about the person’s self?” The obvious answer is that the self processes are intrinsically tied to the client’s psychological and physical health. As such, this literature provides further information about the mind-body relationship. Putting this another way, some people appear to have adaptive health-help-health person-based processes. This leads us to the discussion next of the individual differences person-based processes.

**Individual Differences Issues.**

The study of person-based processes also has been advanced by psychologists who have studied variability among people along some dimension of interest. This work is typically theory driven, and in many ways is similar to the approaches used for studying the self. Investigators usually begin with an observable dimension of comparison (e.g., gender), or a hypothesized dimension of comparison (e.g., locus of control, hope, explanatory style, etc.), and construct a theory about the nature of the principal characteristics underlying this dimension. Then, a measure (typically self-report) of the particular individual differences dimension is developed so as to meet acceptable psychometric standards. Next, the scale is validated in order to assure that it measures what it purports to measure. Lastly, the measure is used to make predictions about the particular behaviors of interest. In the case of this handbook, the behaviors predicted by the various individual differences measures involve psychological and physical health.

The interface researchers using this individual differences approach have generated an increasing number of theories and associated measures aimed at predicting health-related outcomes. What is not clear, however, is the nature of the discriminant validity of these scales. In the spirit of the interface, we would encourage the various researchers to continue their consideration of the overlap in the various theories and measures. If there are common factors underlying the various theories and related individual differences measures, then the understanding of these factors may simplify our unraveling of the most adaptive health-help-health person-based processes.

Many of the researchers exploring self and individual differences issues have typically made an
implicit assumption regarding the underlying motivation for the health-help-health sequence. That is, many of these models are based on the assumption that the normal health-help-health sequence is characterized by (a) people in a positive state of health (psychological and physical) who (b) engage in natural, intrapersonal coping processes (the “help” in this framework) (c) in order to maintain their positive state of health. An implicitly assumed corollary to this pattern of normal help-health-help sequencing is that (a) when people find themselves in a negative state of health, (b) they will engage in natural, intrapersonal coping responses (the “help” in the equation) (c) in order to reestablish their positive state of health. Such intrapersonal models are thus based on the assumption that people have a propensity toward positive health, whether this means that they are sustaining or recapturing it.

One question that may arise is whether people would purposefully maintain a negative state of health, or may purposefully attempt to move from a positive to a negative state of health. In other words, is the “help” in the health-help-health intrapersonal sequence such that the person purposefully attempts to engage in self-defeating or self-destructive acts? This latter point is relevant for those people who do not evidence the adaptive aspects of the particular self or individual differences models. In a recent review of this latter question, Baumeister and Scher (1988) reviewed the available evidence with nonclinical populations. They conclude that there is no support for the notion that normal people intentionally engage in self-destructive behavior. This finding supports the implicit assumption of many of the self and individual differences models in this handbook.

Interestingly, however, Baumeister and Scher (1988) found evidence to support the fact that people engage in self-destructive behavior. This hardly comes as a surprise to anyone who reads the newspaper, or anyone who has done therapy, but based on their review of the literature, Baumeister and Scher provided the clarifying evidence that this seemingly self-defeating behavior occurs under two circumstances. They wrote,

Such unintended or tradeoff motives may characterize the maladaptive “help” styles that the various authors in this handbook describe as they develop their self or individual difference models.

In this latter sense, some people have naturally occurring help intrapersonal processes that are counterproductive in achieving their overall goal of remaining positive. It is important to reemphasize, however, that even such persons may well be doing the best that they can to secure a reasonably positive state of health.

Environment-Based Processes

No firm line separates the personal from the interpersonal. The self, for example, is at once a private, personal view of one’s capabilities, but at the same time is influenced to an extraordinary degree by interpersonal factors. Similarly, one’s health is at once a product of person-based processes and environment-based processes. We consider several of these externally oriented processes below, including interpersonal, diagnostic, and treatment issues.

Interpersonal Issues

Social psychology rests, at its core, on the assumption that an individual’s thoughts, feelings, and behaviors are inexorably and ubiquitously influenced by other people. When this assumption is brought to bear on problems of adjustment and health, the result is an interpersonal view that assumes the following (Maddux, 1987):

- Psychological and behavioral problems—or problems of human adjustment—are essentially social and interpersonal processes.

- The distinction between normality and abnormality is essentially arbitrary and is the product of social norms that were derived in social settings and are enforced in social settings.

- So-called ‘abnormal’ social or interpersonal 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.

- Most, and possibly all, clinical interventions based on psychological principles, regardless of their theoretical foundation, focus on changing what we think about, what we feel about, and how we behave toward other people. (pp. 29–30)

Such an interpersonal approach does not transform the individual into an empty pawn caught up in the interplay of social forces. Rather the person is assumed to be an active choreographer of the
interaction minuet; a sensitive perceiver who is attuned to the interpersonal meaning of the social setting; a tactful interaction partner who selects particular courses of actions depending on personal interactional tendencies and their appropriateness in the particular situation; a selective pragmatist who seeks out situations and interaction partners while avoiding others; and a stubborn negotiator bent on confirming his or her own social identity and definition of the situation.

The chapters in this handbook attest to the burgeoning study of the interpersonal processes as they operate routinely to promote and maintain health during times of stress and times of complacent calm, and how tears in the fabric of our interpersonal relations can undermine adjustment. Although social psychologists have long contented themselves to study short-term attraction, the work discussed in the chapter by Fincham and Bradbury, as well as the chapter by Jones and Carver, illustrates a growing interest in long-term relationships, loneliness, and the impact of these on health. Also, as if heeding Carson’s (1969) plea for a more detailed analysis of Harry Stack Sullivan’s (1953) theory of interpersonal processes, the separate chapters by Kiesler and Strong review the implications that an interpersonal approach holds for diagnosis and treatment. These efforts bespeak the considerable progress made in the last decade, but they also hold the promise of even more successful effort as we move toward the year 2000. As Berscheid (1985) noted, researchers and theorists have been content to cover their theoretical canvases with broad brush strokes, leaving whole sections of the picture unpainted. It remains for future investigators to exploit more fully the useful implications of an interpersonal approach to adjustment.

**Diagnostic Issues**

Beyond the new information that the authors in this handbook present in understanding the processes that underlie clinical judgments, especially the previous propensity to perpetuate a “fundamental negative person bias,” the suggestions and implications of these chapters for improving the procedures and practices are noteworthy for applied psychology in general and health in particular. Many previous writings on the topic of diagnosis have taken the tact of highlighting all the pitfalls, as well as engaging in “clinician-bashing,” in which practitioners are faulted for perpetuating “the problem.” This handbook’s authors, however, take a more constructive stance. One of the most useful messages conveyed in this set of chapters pertains to the importance and necessity of looking to the situation in order to better understand how the person is functioning. Assessment must take into account the reciprocal relationship between the person-based and environment-based forces. For all the work that has been done on the person side of this equation, including the chapters in this handbook that describe advances in self and related individual differences measures, there has been little integration of these developments into the diagnostic activities of practicing clinicians who are employing the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980) (Kiesler’s chapter is a noteworthy exception). One obvious goal of interface scholars, especially in regard to the health perspective, will be to have an impact on the subsequent revisions of the DSM III. As such, many of the points made in the new theory and research on the self and individual differences need to be considered and incorporated in the forthcoming versions of DSM III.

Just as we need to attend more to the environmental forces, both in conjunction and in reciprocal interaction with person forces, there is also a need to consider the valence of the information. As Beatrice Wright argues in her chapter, it is appropriate to look at both the weaknesses and the strengths of the person whom we are diagnosing. By examining the strengths, the prevailing negativity bias may be balanced as we form a diagnostic impression. Taken together, as Wright reasons, it is further possible to conceptualize clients in a two-by-two matrix, in which we look at the strengths and weaknesses both of the person and the environmental levels. The literature on diagnosis suggests that one cell in this four-celled matrix has captured the bulk of our previous attention when we engage in professional assessments. This cell, of course, is the one focusing on the weaknesses in the person. Our position is not that this cell lacks important diagnostic implications, but rather that it is only part of the picture. In keeping with our focus on health as encompassing the bad and the good, the other cells in this matrix need to be considered because they contain valuable information. In fact, in the degree to which the diagnosis is linked to the treatment (see below), then these other cells are critical to the forming of the best plan for interventions.
COMMENTARY 1:

Progress Happens, But Slowly:
A Brief Personal History of the Social Animal Perspective
Robert C. Carson
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It is now a commonplace observation, despite divergences in language and emphasis, that most of what we conceive as human personality is in fact the residual scriptlike or schematic influences of the person's past interactions with others on his or her present ones. Personality is therefore an inherently social-psychological phenomenon. Perhaps because my own training as a clinical psychologist was for its day extraordinarily infused with the Sullivanian perspective, I came very early on to take this unity as a given. I was therefore most pleasantly surprised 20 years ago by the reception accorded my Interaction Concepts of Personality (1969), which I had viewed as a mere updating and modest systematization of the multiple intersections of social and clinical psychology, ones I had assumed to be obvious to nearly everyone. Clearly that was not the case, and in retrospect I also can appreciate that this work struck a chord in some because it offered a plausible alternative to the absurd choice of "person" versus "situation" during the opening salvos of what was to become one of psychology's most pointless but enduring controversies.

While this bit of personal history readily serves as a reminder that psychology as a discipline is not immune to the peril observed in Santayana's gloomy forecast about forgetfulness, my main purpose in recounting it is to illustrate how far we have come over the past two decades in achieving consensus on the main components and experiential (there are, to be sure, other sources as well) roots of personhood. As I read the evidence, there is now an unprecedented and truly remarkable confluence of thinking on this topic, all of it pointing to the centrality of interpersonal history in shaping our prepotent response dispositions and hence to a degree the kinds of situations to which we expose ourselves, and indeed the manner in which we construe or process these situations in assigning meaning (including the meaning stressor) to them. A certain continuity of personhood, even maladaptive personhood, is assured in such a system because environmental reactions routinely confirm the person's already established interpersonal realities.

Impressive as is this convergence of thinking from many sources, however, it must be noted that the constituent ideas could hardly qualify as revolutionary, or even counterintuitive. On the contrary, when concisely stated as above, they seem today rather obvious and pedestrian—not the sort of thing to provoke either enthusiastic adoption or strong dissent. If we have come a long way then—and I believe we have—the progress has been neither rapid nor marked by anything remotely resembling a dramatic breakthrough, as happens sometimes in fields whose observational instruments more closely track what is contemporaneous high tech. Rather, we have an instance of what Meehl (1978) called "the slow progress of soft psychology."

As we approach the 21st century, and as psychology assumes what I believe to be its manifest destiny as the final frontier of medical science, I for one do not anticipate that the road will be any easier, or that genuine progress will be any more clearly marked by dramatic discoveries that presage entirely new directions. Rather, I anticipate a slow accretion of wisdom, punctuated by the explosion of many blind alleys—as, for example, has already occurred in relation to the Type A behavior pattern. Wrestling with the psychological dimensions of the immune response, already known to be incredibly complex in organization, will, I suspect, severely test both the patience and the mettle of the young investigators now being prepared for the battle. I wish them well, and I advise them not to forget that humans are, as much as anything else, social animals.

Lastly, assessment and treatment must be integrated. In a common scenario, the diagnostic procedures may play little or no role in the subsequent interventions that are employed with people. Our view, and it is a strong form argument regarding the underlying reason for professional diagnosis, is that the diagnosis must be linked to the treatment procedures in order to warrant its continued existence. Of course, we are not so naive that we can ignore the autonomous status that diagnosis has achieved in the general mental health field. Indeed, there are large publishing industries and technologies (e.g., witness the recent emergence of computerized testing procedures) that fuel the continued existence and popularity of diagnostic tests and testing. Our point is that often the diagnostic process appears to have taken on a life of its own. Somehow, the hyphen needs to be put back in the phrase "diagnostic-treatment sequence."

Treatment Issues

Some would argue that the ultimate test of the usefulness of the social/clinical interface relates to whether it can generate therapeutic strategies that
will not only be understood with regard to how they work, but they will actually be used by practicing clinicians “in the trenches” (see commentary by Mark Snyder on this point). The former goal of developing theories about how treatment works is explored by the authors in this handbook who have written about various treatment issues. The question of whether these or other procedures will find their way to “the trenches” is, at yet, unanswered.

Perhaps a good starting point in discussing treatment issues is to go to the bottom-line question, “Does it work?” The answer appears to be yes when this question is applied to the results of meta-analyses studies conducted since 1977. Using statistical procedures for collapsing across treatment outcome studies conducted by a multitude of different investigators, Smith and Glass (1977) published the initial meta-analysis study in which the benefits of psychological treatment were documented. In these meta-analysis studies, the sizes of the positive outcome changes evidenced by people receiving specific psychological treatments (varying in terms of their procedures) are compared with the sizes of positive outcome changes found in people who do not receive such treatments. Meta-analysis studies subsequent to the original Smith and Glass one consistently have provided support for the effectiveness of treatment (e.g., Andrews & Harvey, 1981; Barker,

**COMMENTARY 2:**

Social Psychology and Clinical Practice: The Therapeutic Imperative

Mark Snyder

University of Minnesota

I am of the school of psychology that takes it as an article of faith that, as Kurt Lewin proclaimed many years ago, there is nothing so practical as a good theory. As much as I have been invested in advancing the state of theory in psychology, I have always believed that one proof of the utility of developing psychological theories is in their application. This is not to say that I believe that the agenda for theoretical work in psychology should be set by applied considerations. Rather, I believe that ultimately the more we work to create better theories in psychology, the more psychology will be able to address practical concerns in people's lives and in society at large.

In recent years, much has been said and much has been done to define the “interface” of social and clinical psychology. Undeniably, this union has been a fertile one, producing much empirical and theoretical work, as this handbook attests. Those who have labored at the interface have much to say about the problems of individual and social functioning. I wholeheartedly endorse, applaud, and encourage these efforts. There is, I must admit, a somewhat self-serving edge to my words of praise. After all, I have gone to great lengths to spell out the implications of my work on self and identity for understanding the origins and treatment of problems of adjustment (Snyder, 1987) and of my work on social relationships for understanding interactions between therapists and their clients (Snyder & Thomsen, 1988).

Yet, my purpose here is not all cheerleading. As thrilled as I am by all the research generated by the social-clinical interface, and as impressed as I am with the considerable utility of social psychological perspectives to conceptualize clinical issues, I must confess that, for me at least, there is something lacking. My commitment to the “nothing so practical as a good theory” dictum compels me to speak on behalf of those who actually practice the clinical arts. If I labored in the trenches of clinical practice, if I were a therapist or counselor doing battle day in and day out with the problems that brought my clients to me, I would have one question. Where are the treatments, where are the interventions, where are the therapies generated by the interface between social and clinical psychology?

Quite simply, I am suggesting that the bottom-line consideration in evaluating the fruits of the social-clinical interface may be the therapeutic procedures it produces. Now do not get me wrong. I do expect therapies based on the theories and procedures of social psychology to be developed, just as therapies based on principles from other domains of psychology (e.g., learning, cognition) have been systematically developed and refined. And my nagging may prod things along just a bit. Of course, even if and when social-clinical therapies emerge from the interface (and I am not so impatient as to ask for immediate delivery), they will find themselves in a crowded marketplace. Already, there are hundreds of brands of psychotherapy competing for the allegiance of practitioners. Yet, when it comes to fulfilling the promise of the social-clinical interface, I cannot help but believe that the proof of the pudding just may be in the therapeutic enterprise; that is where theory and research on the interface will prove just how practical they can be.
Funk, & Houston, 1988; Landman & Dawes, 1982; Prioleau, Murdock, & Brody, 1983; Shapiro & Shapiro, 1982).

The behaviors examined in these outcome studies are many and varied. To name but a few, these have included anxieties and phobias of various types, insomnia, depression, and relational (marriage, parenting, dating) problems. Further, studies use observable outcomes, self-report outcomes, and sometimes both. Although this diversity of outcome measures is impressive, it also is the case that researchers vary widely in how they conceptualize and measure the actual outcome changes. Likewise, there is some question about the adequacy of the measures and operationalizations of change (see the commentary by Hans H. Strupp for several concerns about the way that outcome is used in research). A related point to be raised in the context of our present attention on health-related outcomes is that future researchers will need to include observable, quantifiable, and valid indexes of physical health. Self-report measures of health have been more typical, but we would recommend using these in conjunction with "harder" measures of physical health.

Although previous results provide support for the effectiveness of treatments, there is considerable room for improvement. One of the major tasks in this regard will be to maximize the change that we can engender in people through our treatments. Further work is warranted in explicating the best person by treatment matches for effecting change. Some work has been done on this topic, most notably the client-therapist matching (see Beutler and others, this volume), but there is much more that we can learn about how the person-based processes interact with the environment-based treatments. Such work may come from the individual differences researchers who will increasingly want to examine the interactions of their person-based constructs with various types of treatment. Conversely, treatment researchers will want to turn to diagnostic or individual differences variables to expand the power of their interventions.

Another set of related issues about the general power and effectiveness of treatment pertains to transfer and maintenance of change (see Karoly, this volume). Although change can and does occur in the short-term through treatment, the sobering fact is that the generalization across settings (transfer) and across time (maintenance) often is rather meager in two senses. First, the available research suggests that generalization simply does not occur for many clients. Second, researchers tend not to take measures of change across settings and time, and as such there is not sufficient attention paid to these important issues. We would agree with the commentary by Arnold P. Goldstein. He asserts that more attention needs to be given to embedding generalization augmentation strategies into the structure of the treatment itself, and to involving the client's eco-system (parents, peers, employers, teachers, and spouses) in the treatment.

Having argued for the continued development and mapping of person-by-treatment interactions, we would like to make a closing, seemingly inconsistent comment. While we applaud and encourage the subsequent technological work that needs to be done in this regard, we would hasten to emphasize our view that it is the underlying theory that should be the focus of generalization rather than the technology. We will never achieve a level of technological sophistication whereby we can absolutely match people and treatments, but the useful theory has the inherent flexibility to be applied to a given client under given circumstances. To have a valid theoretical perspective to apply to our clients, in our estimation, is the key to the treatment processes that we employ. In this vein, we are reminded of a successful gardener who continually works with the roots of a plant rather than merely focusing on the leaves. To the credit of the authors of this handbook who have written on the topic of treatment, there is an obvious thrust in regard to the importance of theory. It is our view that the interface researchers are especially well qualified to develop and test such theories.

Caveats

Against this backdrop of encouraging theoretical growth and empirical results, we must consider limitations as well as strengths. With regard to the person-based processes, it should be noted that our individual differences measures account for relatively small amounts of self-reported health behaviors, and even less of the actual physical health markers. This is reminiscent of Mischel's (1968) earlier skepticism with regard to the predictive power of personality measures.

There are ways to increase the predictive capabilities of self-report individual differences measures to health outcomes, assuming that (a) the underlying theory is heuristic and (b) the respond-
COMMENTARY 3:

Psychosocial Treatments: Some Unsolved Problems
Hans H. Strupp
Vanderbilt University

Three critical issues continue to bedevil the measurement of change in psychosocial treatments of all kinds. First, there is the problem of outcome. Because of its central importance for all research concerned with therapeutic change, clarification of the outcome problem is urgently needed. Critical questions include the following: (a) What kinds of specific changes are expected as a result of particular therapeutic interventions? (b) Who judges whether a given change is to be characterized as an improvement or as a negative effect—the patient, society, or the therapist? (c) Is it reasonable to combine judgments derived from the foregoing domains, or should they be kept separate? (d) What instruments or measurement operations are adequate to assess changes? Across-the-board changes, as measured, for example, by the Minnesota Multiphasic Personality Inventory and other "inventories," or single indices like behavioral avoidance tests, have increasingly emerged as inadequate. As elaborated by Strupp and Hadley (1977), the issues to be resolved are research tasks only in part; they also involve to a significant degree issues of researchers' beliefs, societal standards, and public policy, which in turn call for a thorough analysis of social values and the manner in which they enter into judgments of mental health and therapy change.

A second issue involves techniques versus nonspecific factors. This issue continues to be a topic of central theoretical and practical importance. There is as yet limited evidence that specific techniques are uniquely effective apart from nonspecific factors; indeed, earlier enthusiasm about the vaunted superiority of certain techniques (e.g., systematic desensitization) has given way to more sober assessments as greater weight is being assigned to contextual factors; that is, the patient-therapist relationship in which techniques are always embedded. This point also underscores the futility of clinical trials in which techniques are decontextualized.

Third, there is the problem of diagnosis. There is a great need to describe more adequately patient populations for whom particular forms of treatment are intended. The traditional diagnostic categories, as most researchers and therapists recognize, are woefully inadequate, but so are taxonomies based purely on behavioral indicators. So-called simple phobias in a presumed "normal" personality are rare, and there is increasing appreciation that the person's total personality makeup (character) or social modes play a part in the presenting disorder. There are still only limited conceptual schemes for describing patients and their problems, a situation seriously impeding outcome assessments and treatment comparisons. In particular, we must develop better ways of assessing the totality of the patient's functioning—its strengths and weaknesses—within which descriptions of what constitutes a "problem" in need of therapeutic modification must take their place.

There is a great need for studies in which more sharply defined techniques are studied in relation to particular patient-therapist combinations, which again must be defined more stringently. Answers from such studies will not only shed light on the relative importance of particular techniques and particular combinations of personality factors, but they also have important implications for optimal assignment (matching) of particular therapists to particular patients in clinics and other treatment facilities.
COMMENTARY 4:

Toward Clinical Utility:
From Theory to Technique to Situation to Person, and Back
Frederick H. Kanfer
The University of Illinois at Urbana—Champaign

Psychological treatment is a problem-solving enterprise. Therefore, a clinician must be familiar with a body of knowledge about phenomena that relates to the problem at hand, techniques for translating such knowledge into effective operations, and some rules or heuristics that include which body of scientific knowledge is most relevant to the problem. Rapprochements of social and clinical psychology that relate two or more subdomains of science (e.g., interpersonal or decision-making processes and pathological processes) have made excellent progress, as has the translation of principles into operation (see Section III of this handbook). A critical shortcoming, however, lies in providing heuristics for matching techniques to characteristics of situations and patients. Barber (1988) has called attention to this lack of guidelines on how to use models and to map problems onto them. Among others, Hayes, Nelson, and Jarrett (1987), Kanfer and Nay (1982), and Dance and Neufeld (1988) have dealt with various facets of the problem of utility (i.e., developing specific guidelines and predictors that take into account patient characteristics, problems, and situations). But to date the bridges have built mostly from theories about individual differences to treatment operations. The translation must be enriched by consideration of the realities of the context in which therapy occurs; such realities usually transcend specific psychological subdomains and unidimensional models.

Providing a fruitful interface between theory and application requires several steps. In a utopian scenario, the literature would offer, on the one hand, guidelines on how to formulate the clinical problems in the technical language of psychological science. On the other hand, the clinician would find detailed statements of the implications and applicability of research and theory to everyday problems. Once this had been achieved, a clinician would then be assisted by guidelines for selecting among the many variables those that not only have a statistically significant effect but an ecologically useful impact on the practical situation. A conceptual formulation could then be made of the problem, the desired outcome, and the interventions required to achieve it. Intervention strategies derived from this formulation would be translated into available technology and operations appropriate for the individual case. The client's life contexts and the characteristics of the therapeutic setting also would be examined to assess their probable impact in facilitating or blocking successful outcomes. Because the dynamic aspect of human existence involves continuing change in interrelationships among components of the person-environment, static models of basic psychology will have to be supplemented and expanded. To attain clinical utility, scientific enterprises cannot stop with descriptions of interrelationships of statistical significance. They must also contribute toward analyzing the relative power (utility) of principles and methods for different individual situations and the robustness of changes both over time and for different individual contexts. While current trends are moving in this direction, these efforts have just begun. Ultimately, it should be possible to train clinicians not only to be familiar with psychological science but also to behave in ways that enact the implications of theory and research in everyday practice.

component of hope) are to some degree "hardwired." The sophisticated interface studies linking genetics and the various psychological variables have yet to be done, but will be important if we are to advance our understanding of subsequently developed explanatory theories.

Another caveat involves our rather short-term temporal approach to conducting research on health-related outcomes. In other words, what we know so far is based on studies involving short temporal envelopes (anywhere from a few minutes to a few months). Health outcomes undoubtedly are derived from long-term patterns of behavior, and we heretofore have not had the time, energy, and investment (both psychologically and mone-

tarily) to engage in the necessary long-term analyses of health-help-health sequences. It is as if we have taken snapshots of a process that is, at minimum, a long movie. Because of this, our understanding of the health-help-health process is somewhat delimited.

Perhaps the last caveat is also the most difficult. In reading the work that the present scholars have generated, as well as other work in journals and books, it is apparent that there is no consensus on what is meant by the term "health." Our resolution, as articulated in the first chapter, was to define health as consisting of the psychological/
COMMENTARY 5:

Generating Transfer:
Toward a Technology of Transfer and Maintenance Enhancement
Arnold P. Goldstein
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Though the implicit belief to the contrary often remains strong, most successful psychological treatments rarely function as inoculations against the later return of the psychological states that engendered the initial seeking of treatment. The inoculatory belief is made explicit in the goal statements of some psychotherapeutic approaches, and in aspirations regarding "enduring personality change." It appears more implicitly in the "train and hope" aspiration of other approaches. Yet considerable evidence from many sources, involving diverse therapeutic approaches employed with many different types of clients, consistently reveals that both major categories of generalization—across settings (transfer) and across time (maintenance)—do not occur in a substantial proportion of outcomes. In terms of both the real-world use of, and enduringness of, therapeutic gains, much of the time we (change agent and client) have largely wasted our time and effort. That, as they say, is the bad news. The good news is that during the past decade three highly promising, complementary strategies for generating generalization of treatment gains have emerged. Each has gathered at least a moderate level of empirical support, and each is clearly a worthy candidate for both further experimental evaluation as well as continued clinical utilization.

The first generalization augmentational strategy concerns the internal structure of the treatment itself. Growing evidence suggests that generalization of gain will be more likely when the psychological treatment offered is both broad and multichannel. Band width in this context refers to the breadth or number of client qualities targeted by the treatment; multichannelness refers to the range of different modes of client response targeted, respectively, by the different components of the treatment. Our approach to chronically aggressive adolescents, aggression replacement training, consisting of separate but integrated weekly sessions of prosocial skills training (the behavior-targeted component), anger-control training (the affect-targeted component), and moral reasoning (the values-targeted component), is an example of such a broad band, multichannel treatment. Demonstrations of reductions in recidivism associated with this intervention are initial evidence of its generalization-promoting efficacy.

The second recommended strategy involves the incorporation into the structure of the treatment, or the manner in which it is delivered, of an array of transfer- and maintenance-enhancing procedures. These several methods have their initial roots in laboratory research on verbal learning, but in recent years have been examined for their efficacy in clinical contexts. The five transfer-enhancing procedures include (a) provision of general principles (general case programming); (b) overlearning (maximizing response availability); (c) stimulus variability (train sufficient exemplars, train loosely); (d) identical elements (programming common stimuli); and (e) mediated generalization (self-recording, self-reinforcement, self-instruction). The five maintenance enhancing procedures include (a) thin reinforcement (increase intermittency, unpredictability); (b) delayed reinforcement; (c) fade prompts; (d) booster sessions; and (e) preparation for real-life nonreinforcement (teaching self-reinforcement, relapse and failure management skills, and graduated homework assignments).

The final strategy for encouraging real-world enduring use of treatment gains, overlapping in some of its particulars with those described in the previous paragraph, lies external to the treatment itself and, in one form or another, involves reaching into the client's ecosystem. Transfer and maintenance will be enhanced if the change agent, with creativity, energy, and persistence, seeks to maximize the degree to which the client's interpersonal environment (parents, peers, siblings, employers, teachers, spouse) are promotive of such reinforcement. In the relevant research and clinical efforts, such promotive behavior by the client's real-world significant others has typically been operationalized by continuation of the treatment itself with the parent, peer, and so forth serving as change agent, and/or the mobilization and programming of such persons as skilled contingency managers, providing reinforcement as appropriate for continued desirable behaviors, as well as prompting, coaching, and perhaps punishing for continued undesirable behaviors. Reaching into the client's ecosystem also may be accomplished by teaching the client to use reinforceers that occur naturally in his or her environment. The client is taught to identify easily reinforced behaviors, and use both reinforcement recruitment and reinforcement recognition.

The diverse concretizations of these three strategies constitute the current technology available to the treatment community for the purposes of generating generalization of client gain. It is an underused technology, yet one that must be employed, investigated, expanded, and promoted if we are to serve our clients in a more fully ethical and effective manner.
COMMENTARY 6:

Evaluating Psychosocial Factors in Health
Richard S. Lazarus
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Taking care of one's health through the management of stress, and via active programs devoted to exercise, diet, and avoiding substance abuse are all the rage, and the indicated values and knowledge base have spawned a number of new disciplines sometimes identified as health psychology or behavioral medicine. This comment affords me the opportunity—which I hasten to take advantage of—to remind health-oriented professionals about how little we know about whether and how much we can do to effect long-term health outcomes. We seem to have accepted unwarily the medical obsession that we can control health—even chronic health—and any intimation that we may have less ability to do this than is commonly presumed is offensive.

I would like to offer four reasons—essentially methodological—why it is difficult to demonstrate unequivocally that there are important psychosocial influences on health even though we all tend to believe that they exist.

First, health is affected by a great many factors over which we have little or no control, but which are probably very powerful influences nonetheless. These include genetic-constitutional factors, accidents, environmental toxins, and long-term life-styles, which involve using harmful agents as in drinking and smoking, and which are undoubtedly of transcendent importance, especially in vulnerable persons. After the influence on health variance that is played by these factors, and probably a host of others of which researchers are only dimly aware, has been taken into account, there may be only modest amounts of variance left to show the operation of psychosocial factors like stress.

Second, health is usually very stable and does not change rapidly, except under special circumstances such as aging or rapidly progressing illnesses. In our research we have found the correlation over a year—with admittedly poor measures—to be about .70. To demonstrate causal influences requires that one show that psychosocial factors produce changes in health, but because of this stability doing so is very difficult (see Kasl, 1983).

Third, to show that stress and coping affects long-term health requires that we measure stable patterns during the time interval in which we make our observations. It is not what happens in a single encounter that is important, but what happens consistently over time. The only solution is either to find processes that are stable or representative of the person—a rather unlikely state of affairs—or to monitor what happens in the time interval of interest. This means sampling what is going on repeatedly, rather than making only a single pre- and post-assessment.

Several researchers (e.g., Caspi, Bolger, & Eckenrode, 1987; Eckenrode, 1984; Stone & Neale, 1984) have begun to realize, in fact, that monitoring a relatively short time interval for stress, coping, and illness symptoms offers a more practical strategy for doing this than trying to study the problem over years of longitudinal research. Along these lines, DeLongis, Folkman, and I (1988), in research using an intra- as well as an interindividual design, showed that certain personality traits, such as the perception of poor social support and negative self-esteem, predicted a rise in illness symptoms following increased daily stress.

Fourth, I believe we will never effectively study the relationship between stress, coping, and health unless we have some conceptual guidelines for what we mean by health, which are not now in evidence. As I have noted elsewhere (Lazarus, in press), if longevity is the criterion of health, then one condition, mucous colitis, seems to have no bearing on the outcome variable, but another condition, hypertension, does; however, if social functioning is the criterion of health, then hypertension has no bearing—especially when it remains untreated by distressing drugs—but colitis does. This example is only one of many that highlights the need for a workable theory of health that would be useful in helping us create a sound measurement strategy for epidemiological and clinical research.

My reason for offering this relatively pessimistic account of our prospects for adequately supporting the contention that psychosocial factors such as stress and coping are important influences on health is not to discourage clinical, social, and personality psychologists interested in health. One hates to be a spoilsport. Rather, it seems to me that these methodological issues are so important that professionals always need to keep them in mind lest they fail to understand what is really known and not known about behavior and health, fail to understand how to go about getting valid answers, and be mistaken about the prescriptions they offer for intervention and self-help. Only sophistication about our knowledge base will help us avoid making outrageous claims that only uninformed laypeople and physicians—who undoubtedly want to believe—would be willing to accept.
physical state that the person is motivated to sustain or change. This definition is obviously an overarching one. It entails both the psychological and physical elements, it emphasizes the person's phenomenology, and it has an accompanying sense of motivation. This definition was chosen because it captures a myriad of other specific health definitions, but it has at least one flaw. Imagine, for example, the person who has a serious physical illness, but who is not yet aware of this phenomenologically. Certainly this person has a health problem from a physiological point of view, but does not have one phenomenologically. Realistically, it may never be possible to arrive at a common definition of health, and it is therefore incumbent on interface scholars to clarify for their audiences what they mean by this crucial term.

BUILDING THE INTERFACE

Challenges to Be Met

The progress that has been made with regard to social-clinical interface does not guarantee a stable future, for the problems that jeopardize its future viability are serious ones (see the commentaries by Sharon S. Brehm, Susan S. Hendricks and Clyde Hendricks, and Bonnie R. Strickland for related discussions). First, there is the historical and continued separation of the clinical and social training programs in departments of psychology. (At some universities, however, the separation is so complete that there is an entirely distinct department or division of clinical psychology. This separation includes the various levels of autonomy, for example, administration, budget, building, and courses.) Although faculty technically may be in the same department, the separations are clear. In some departments the social and clinical faculty may occupy different buildings, and even if they are in the same building, they may have separate floors. Additionally, the programs each have their faculty, students, curriculum, meetings, and administrative structures. In part, some of this separation is driven by the fact that the American Psychological Association has a detailed set of administrative and curricular criteria that must be met by clinical programs in order to attain and maintain accreditation; in contrast, social programs are under no such accreditation guidelines and as such are free to develop more varied administrative and curricular models of education.

It should be noted, also, that the length of the temporal envelope involved in securing a Ph.D. may be another stumbling block. Each program, whether clinical or social, wants us to ensure that the minimum basic entry skills and knowledge are acquired. Therefore, to produce Ph.D.s with an interface curriculum would necessitate extending the time period required to obtain the degree. Neither the faculty nor students may be willing to do this.

In addition to the aforementioned formal boundaries between social and clinical, it also should be noted that faculty members naturally tend to reproduce the education format in which they were trained. Thus, the separation of the training is a replication of “the way we did it at my school.” Also, for a new assistant professor, the interface may seem especially risky because such activities do not fit the clear mold of what a “social” or a “clinical” faculty member is to do in order to get promoted. As one assistant professor put it to the editors at a recent conference on the interface, “It is easy for you guys with tenure to talk and behave this way, but I have to look at what will get me tenure.” In other words, the interface individual runs the risk of being a “marginal person” who is not recognized and rewarded in the context of many present day psychology departments.

Just as the individual faculty may tend to solidify his or her “identity,” support, and reward structure within a clinical or social program, the programs may continue their efforts to solidify their resources within the department of psychology more generally. This means that a particular program argues for its needs (e.g., faculty, space, equipment, etc.), and as such any jointly derived ventures are viewed as threats to the core program needs. The separation is further reinforced by professional networking systems for each subarea. For example, there are journals dedicated to each area; likewise, each has its own set of professional societies or divisions, conventions, awards, etc.

Lastly, we are presently witnessing the inability of scientist and practitioner psychologists to cooperate at the national level. The American Psychological Association has been the formal battle ground for this split, which has occurred because of the inability of various divisions in the national organization to arrive at shared goals and to make compromises. In this vein, the American Psychological Society was formed specifically to respond to the needs of the scientific psychologists. There
COMMENTARY 7:
On Winning Battles and Losing Wars
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The University of Kansas—Lawrence

In 1976, my book *The Application of Social Psychology to Clinical Practice* was published to what, at the time, appeared a deafening roar of indifference. I had thought of myself as carrying on the tradition of pioneers such as Frank, Carson, Goldstein, Heller, and Sechrest. Instead, I seemed to be the end of the line of descent. Fortunately, my initial optimism turned out to be a better predictor than my brief spell of pessimism. The social-clinical interface easily weathered a period of neglect to emerge full of life in the 1980s. Invigorated by creative and talented researchers, solidified by insightful books and chapters, and institutionalized by John Harvey's founding of the *Journal of Social and Clinical Psychology*, the interface prospered. All seemed well.

But was it? Certainly, the interface was firmly established in social psychology. By the mid-1980s, it was unusual to pick up any issue of any mainstream journal in social psychology without finding research relevant to some clinical topic. Although slower to develop, the interface also became increasingly important in the work of researchers in clinical and counseling psychology. As barriers fell, ease of passage could be taken for granted. Surely, all was well.

Not quite. Talking with graduate students these days is like entering a time warp. Clinical students talk "clinical"; social students talk "social." You can make them talk "interface," but for most it remains an imposed, artificial dialect. Social students are eager to conduct research on depression—without ever having seen a clinically depressed individual. Clinical students will master a narrow wedge of the social literature for a research project, but show little or no interest in the larger context. And they are amazed (or amused) if you suggest that social psychology might be relevant to their clinical work. Putting it mildly, the interface seems less than a major force in their intellectual and professional lives.

There are, of course, exceptions. I would suggest, however, that it is unwise to rely entirely on exceptions to carry on the tradition. My hope for "the interface toward the year 2000" is that we would take more seriously our responsibilities for the training of the next generation. They should be better than we are. To be better, I submit, will require a fully integrated training program where students learn "real" clinical and "real" social. True, such a program would require unusual flexibility from the faculty involved and probably an extra time investment of a year or so from the students. Would the potential benefits justify the added effort?

I believe the price would be well worth paying. Consider, for example, the kind of theory and research that would be produced by the graduates of interface programs. One might expect some new solutions to the eternally vexing problem of balancing conceptual richness and empirical precision. Consider also the possible effects on clinical practice. I am prepared to argue that the ultimate test of the clinical-social interface must occur at the level of the consumer. If so, we should not trust our ideas simply to "trickle down." We must develop interface therapeutic strategies, evaluate them, and train people to use them. Finally, consider the profession. In a time of petty quarrels within the American Psychological Association, the scientist-practitioner model is in desperate straits. Are we to retreat within our little niches? Or, shall we rise to the ante and make an even greater commitment to this model within the context of the social-clinical interface? It seems to me that the tradition deserves to be passed along. The battle for acceptance among our peers having long since been won, we can take the time to build a reconciliation that will endure.

has been an "us" versus "them" mentality in this debate, and as such it has many of the qualities of the problems outlined previously in this section.

Drawing a Blueprint

Against this backdrop of potential obstacles, it is important to discuss what can be done to ensure the growth of the interface. Perhaps the first task is to specify the nature of what we mean by the interface. In the past, the interface has involved an intersection of the subareas of social and clinical psychology. This intersection has resulted in a simple touching or connection of the boundaries of the two subareas. The aforementioned definition is reflected in writers who use the phrase "at the interface" in describing some aspect of social/clinical work. This conception of the interface was useful because it satisfied the needs of each subarea. Social psychology was searching to be relevant, to maintain and increase its attention to real-life issues; clinical psychology, having thoroughly explored some of the grand theorists of previous decades, needed new theoretical frameworks for conceptualizing people. With regard to the nece-
COMMENTARY 8:
A "Healthy" Interface:
On the Value of Professional Confidence, Listening, and Ecumenism
Susan S. Hendrick and Clyde Hendrick
Texas Tech University

If the interface is to become an increasing reality toward the year 2000, it seems to us that more psychologists must relinquish their historical arrogance (manifested by feelings of superiority toward other disciplines such as sociology, family studies, and education) and low self-esteem (manifested by feelings of inferiority toward other disciplines such as biology, chemistry, and mathematics), replacing this bipolar behavior with healthy confidence in what we can and cannot do. Once we begin accepting our limitations and honestly seeking ways in which to enrich our research and practice, we will find it easier to become ecumenical, embracing strengths of other disciplines as well as of other areas within our own discipline of psychology. Although we have espoused ecumenism throughout psychology, our focus has been on the interface of social, clinical, and counseling psychology. And our personal knowledge of these three areas involves incidents in which all three have been "guilty" of spending available energy defending turf, or else using it to devalue one of the other areas, and in both cases neglecting the more important issue of how the three areas can work together. We know that it is easier to argue than to negotiate; in fact, the two of us deal with professional competition/cooperation on nearly a daily basis. We disagree on many issues of education (i.e., what constitutes a core curriculum) and training (i.e., how much practicum training [if any] is needed before someone is ready to deal therapeutically with a client). What makes our arguments typically fruitful, however, is a basic respect for the other person as a psychologist, and for the other person's area of the discipline. Without that basic respect, creative dialogue would be impossible. Thus, we believe that every time a psychologist belittles a psychologist from another content area, the interface slips a little farther from our grasp. And every time a psychologist seeks respectful collaboration with a psychology colleague, the interface moves a little closer.

It is always easier to articulate change at the level of the institution rather than at the level of the individual, both because institutional change appears more removed and less personally demanding, and because institutional change happens so seldom that our basic desire for homeostasis is usually satisfied. Certainly, we are not disputing the value of political statements, organizations, handbooks, and the like as driving forces for professional progress. All are necessary for change to occur. However, for something like the interface, change must happen for individuals, or it cannot happen for institutions. We believe that nothing less than massive change on the part of psychologists, encompassing secure confidence about what we have to teach, and open curiosity about what we still need to learn, can provide the future for the interface that it so richly deserves.

sity of theory and subsequent experimental tests with actual people attempting to cope with the vicissitudes of life, it is important to emphasize that these latter values have formed the backbone of these previous interface endeavors.

In our estimation, the social/clinical interface will need to take on a more interactive model of intersection than has previously been the case. That is, we would advocate that the two subareas need to establish an interface in an overlapping sense (see Forsyth and Leary, this volume). In other words, however it is accomplished, what we are calling for in subsequent years are recognized arenas whereby interface psychologists can work together and be recognized and rewarded for such activities. To some extent, this is already the case in some psychology departments where people trained as clinical or social psychologists are prospering. Such people, however, have literally evolved on their own into personifications of interface scholars in that their interests have led them to this integrative stance.

Beyond those professionals who have naturally emerged as manifestations of the interface, there have been a handful of people who have obtained training in both predoctoral clinical and social psychology programs. It is our view, and one shared by other writers (see previous Sharon S. Brehm commentary), that we can not count on this relatively small pool of interface psychologists to "carry the torch" in the manner that it deserves. What is needed are educational contexts wherein students can garner Ph.D.'s in the interface. This will mean that present faculty will have to have the vision, and negotiating skills, to develop or evolve such programs in the context of
COMMENTARY 9:
The Viability of the Discipline of Psychology:
A Plea for Integrating Science and Practice
Bonnie R. Strickland
University of Massachusetts at Amherst

The issues faced by psychologists as they approach the 21st century and their second hundred years will continue to focus on the growth and survival of the discipline. The first hundred years of psychology defined the science and profession. The second half of the 20th century also marked the establishment of the practice of psychology as an independent health-care profession.

Psychology has enjoyed enormous successes but these have led to the inevitable strains that occur as any science matures. With an explosion of knowledge in the science and application of psychology, it is increasingly difficult to be broadly trained, and one's interests move naturally toward specialized areas. Such evolution raises continued concerns about a core of psychology and whether the discipline can remain unified. Moreover, because psychology is so broad, we increasingly interact with other disciplines or find ourselves involved in establishing and developing new fields of inquiry, such as health psychology. Some find the new endeavors so different from their earlier experiences that they leave the field of psychology, or no longer call themselves psychologists.

Psychology has also been unique among the major sciences and professions in trying to combine the generation of knowledge with its application. Because scientists and practitioners often hold different values and work in different venues, a true integration of science and practice has often been quite difficult. Health psychologists, in particular, must of necessity be knowledgeable in both basic and applied arenas and practice their psychology, as appropriate, within the highest standards of ethical practice.

So, overriding issues, especially relevant to social and clinical, and health psychology, have to do with how we maintain and nourish the discipline of psychology so that social and clinical psychologists continue to inform and be informed by the traditional core areas of psychology. Additionally, social psychology, as both a basic and applied science, and clinical psychology as a practice, are deeply affected by the problems of integration that face psychology.

The protection and enhancement of the discipline are essential, not only for the partisan support of psychology, but because psychology is that contemporary science that is not reductionistic but gives attention to a total, organismic functioning. No other science emphasizes behavior and focuses on individual actions within a situational context. We cannot afford to lose a discipline that seems so clearly necessary for understanding and alleviating human problems. We must continue to link health psychology to both our basic and applied knowledge base in general psychology.

Social and clinical psychology seem to be uniquely poised to advance and apply knowledge of the human condition. We will need, however, to forge new models for preserving the discipline, for communicating across areas, and for integrating the science and practice of psychology.

existing departments with separate clinical and social programs. This will be no easy task. As Seymour Sarason (1987) noted with regard to such proposed changes,

Graduate programs and departments, like the universities of which they are part, are conservative organizations that adhere tenaciously to tradition, existing practice, and the marketplace. The changing of curricula encounters a field of mines. (p. 223)

There certainly are psychology departments where an interface program might flourish, but this important task remains to be accomplished. If and when such programs are established, the true overlap in social/clinical training will be achieved. This task will involve attention to what the constituent faculties consider to be the "basics" in social and clinical psychology, with special attention also being paid to meeting the requirements of the American Psychological Association for the accreditation of clinical programs. Undoubtedly, these interface programs will require a somewhat longer period of training. It is this fact as well as the accompanying problems (e.g., securing another year of graduate student support money) will need to be resolved by the faculty.

Once established, such programs would entail a reward structure for interface faculty. Also, these programs would provide a source of employment for future interface-trained graduates. The major
COMMENTARY 10:
Roots and Growth: The Role of Theory and Laboratory-Experimental Methodology
John H. Harvey
University of Iowa

Indeed there are issues and problems that deserve our consideration as we move toward the next century and a likely prosperous era for this interface of clinical-counseling-social/personality psychology. Editors Snyder and Forsyth were wise to include such a futuristic section in this book. The one issue I wish to emphasize (as a social psychologist) is the enduring value to clinical and counseling scholars of laboratory research on basic social and personality processes. I would be one of the first to question the external (and sometimes internal) validity of laboratory-experimental research for advancing our understanding of many complex human problems. At this border, the lab and the experiment can only serve as adjunctive approaches to surveys/interviews/archival probes of the target phenomena in relevant populations. Nonetheless, taken as an indispensable enterprise for developing basic knowledge, the lab-experimental approach can be pursued in parallel to these more naturalistic-real world approaches and should have a clear, dignified stature in the evolution of this hybrid domain of contemporary psychology. Without such an approach, the development of several major current theories in clinical psychology (e.g., attributional analysis of learned helplessness and depression) would be retarded, or nonexistent. Similarly, basic work on special topics such as cognitive dissonance, reactance, and the actor-observer hypothesis in attribution and more generally work on theories of persuasion, social perception, stigma, group process, altruism, aggression, and violence have contributed in a fundamental way to more clinically relevant research and therapy in the last three decades—as the chapters in this book attest. So as we look to the era of the 21st century, let us not forget our roots. We owe so much to the theoretical and methodological thinking that pioneers such as Kurt Lewin and Fritz Heider bequeathed us. Those traditions also speak to openness and respect for diverse points of view. My hope is not only that the interface will be flourishing in 2000, but that it also will continue to embody such traditions and respect for basic work on social and personality processes.

employment arenas, however, obviously would be traditional clinical and social programs, as well as the multitude of other jobs where present applied social and clinical psychology graduates obtain employment. Further, once graduates of such interface programs enter psychology department settings, it may be possible for them to establish more interface programs. If the interface is the viable intellectual and practical hybrid that we believe it is, then it is obvious that the key next step is to establish the first such interface predoctoral programs.

Beyond the predoctoral programs, another vehicle for expanding the pool of social/clinical interface scholars involves postdoctoral training. For the present and until such time that predoctoral programs are established, it is possible for students who have obtained their Ph.D.s in either social or clinical psychology to obtain postdoctoral experiences (1 to 3 years) in the complementary subarea. Given the sheer amount of knowledge and skills that are necessary for a person in the interface, the notion of the availability of postdoctoral experience as a supplement is important. This present “building from a base” model of education is available to potential interface students.

Beyond the establishment of interface graduate training programs, there are other available building blocks for the interface. As a means of networking and disseminating information, for example, there is a need for continued conferences of interface scholars to share ideas; similarly, the development of societies or divisions of relevant psychological associations (with the usual newsletters) may produce further opportunities. Already, many clinical and social journals are filled with content that epitomize the interface. Additionally, the operation of the Journal of Social and Clinical Psychology is yet one more index of the specific development of publication outlets for interface materials.

Lastly, the interface may weather the present difficulties because some of the important developing subdisciplines of psychology are implicitly involving social, clinical, and interface scholars. As a case in point, consider the subtitle of this
handbook, "The Health Perspective." As this sub-discipline has emerged, it has offered a relatively "turf-free" content arena in which there was a naturally occurring cooperation among social and clinical psychologists (as well as professionals from other disciplines). In the extent to which other new applied content areas capture the attention of psychologists in subsequent years, similar opportunities for interface scholars will appear. At this time, the health perspective provides an excellent theme for the interface, but in future years a different theme may provide a better integration.

On the Building of a Home: The Lesson of the Three Little Pigs

This summary chapter has been filled with visions of the future for the interface of social and clinical psychology. Although there are caveats and difficulties that we must address as we face the future, it is our strong belief that we need to move beyond a shared commons from which the various subareas of clinical and social "feed." In this sense, to return to an earlier discussed definition of the term interface, we are advocating more than a simple intersect of the two subareas. Indeed, what is needed is a "house" that we can share. Although some of the "rooms" may look strangely familiar, as we note in the close of the introductory chapter of this handbook, now we should build a house where the rooms are readily identifiable as "ours." This will change the house into our home. Further, as the present chapters attest, such building projects by social/clinical psychologists may contribute to our understanding and facilitation of healthy people. But, to continue the work that has been started, it is absolutely essential that we build together. In this sense, we close the Handbook with the following allegorical evolution (Forsyth, 1988, pp. 63–65) of the story of "The Three Little Pigs":

Not-so-long-ago in a not-so-far-away land lived three little pigs. These three little pigs grew up in the same neighborhood, attended the same schools, and shared the same passion: houses. The three were fascinated by the various types of structures inhabited by pigs the world over, and they whiled away many a happy hour puzzling over the nature and design of such dwellings. They could think of nothing more meaningful than dedicating their lives to the scientific study of houses and the ways they can be improved and repaired.

As they grew older, however, the pigs gradually grew apart in values, beliefs, and goals. The first pig became intrigued with understanding how houses worked, and embarked on a systematic study of foundations, arches, doors, and windows. So he bought a big arm chair in which to sit in his straw house and develop theory. He converted his pig pen into an elaborate laboratory where he could test out hypotheses, and erected a large sign for all to see. The sign read: Scientific Pig. Using his arm chair and laboratory, he developed a particularly interesting theory about round houses that had no windows or doors. Although no one had found any of these houses, other scientifically minded pigs thought the work was interesting.

The second pig was also interested in the theory behind houses, arches and doorways. The second pig, however, wanted to use this knowledge to improve houses; to repair misspent houses and possibly make houses of tomorrow better than houses of today. So this pig put a sign in front of his pen that read "Practical Pig," and began helping other pigs build and repair their houses. Soon, practical pig had made so much money that he could afford to build a breathtakingly beautiful house of sticks on a large tract of land in the country.

What, in the meantime, was the third pig doing? Well, it seems that he too was trying diligently to understand the nature of houses. Although scientific pig and practical pig only spoke to one another once a year at their annual reunion, the third pig often visited each one to talk about houses and ideas for improving them. When Scientific Pig would describe his studies of round houses, the third pig would ask what the studies say about the structural dynamics of houses in general. And when Practical Pig would talk about building houses out of sticks, the third pig would ask why sticks rather than stone? After many conversations and much research on houses, the third pig managed to build a house that, though it lacked the beauty of Practical Pig's house, was more useful than the round houses that the Scientific Pig studied.

One day a pig-hungry wolf came to town. When he came to the first pig's pen the wolf said, "I am hungry, and must have a pig for breakfast."

Scientific Pig, rising up from his arm chair said, "Why eat me? Can't you see the long-term importance of my work on round houses?"

"No," answered the wolf as he bit off the poor Scientific Pig's head.

You see, although the first pig had fashioned a marvelous round house of straw and mortar with strong arches and walls, it had no window or doors. It was a fine model to be used for testing predictions about houses, but it didn't protect him from the wolf. The third pig had warned him that building houses with doors would yield both better data as well as safety from predators, but he hadn't heeded his friend's warnings.

Sadly, the second pig was also eaten, for although he had built what seemed to be a safe house, Practical Pig decided to use sticks for the walls. Although the first pig had found that
"weightbearing, rigid barriers fashioned from the woody fibers of trees and shrubs can be rendered dis cohesive through exposure to focused atmos pheric air pressure of excessive magnitude," the Practical Pig felt that the first pig's studies were so artificial that they didn't have any relevance for "real" houses. In fact, he had let his subscription to the Journal for Purely Scientific Pigs (or, JPSP) lapse, so he didn't even know about the problems with sticks. So when the wolf huffed and puffed and blew, the house tumbled down and the second pig fell victim.

The third pig survived (of course). When he saw the wolf approach, he ran into his house and locked the door. The wolf pushed on the house, but the foundation and structure were too strong. He tried blowing on the house, but the stone walls held secure. He tried climbing on the roof, but the carefully crafted masonry gave him no purchase. The hungry wolf, relenting, then left the third pig in peace.

The moral of the story is taken from the monument that the third pig erected to the memory of his departed childhood friends. It read:

Knowledge cannot prosper
When science is one-sided,
The basic and applied must be,
United, not divided.

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