1 Social Psychological Foundations of Clinical Psychology

History and Orienting Principles

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This chapter attempts to build a foundation for the application of theory and research from social psychology to clinical psychology. According to Baron, Byrne, and Branscombe (2006), social psychology is "the scientific field that seeks to understand the nature and causes of individual behavior and thought in social situations" (p. 6). According to the Society of Clinical Psychology (Division 12 of the American Psychological Association, [APA] *www.apa.org/divisions/div12/aboutcp.html*), the field of clinical psychology "integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development [and] focuses on the intellectual, emotional, biological, psychological, social, and behavioral aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels."

Both of these definitions are wide-ranging and cover a lot of territory. In fact, it is difficult to imagine a situation involving any human being that does not involve the "actual, imagined, or implied presence" of another human being. Likewise it is difficult to imagine a situation involving any human being that does not involve some aspect or another of "the intellectual, emotional, biological, psychological, social, and behavioral aspects of human functioning." Can we, therefore, draw any meaningful distinctions between social and clinical psychology? Perhaps not. Although social psychology traditionally has been concerned with more or less "normal" social and interpersonal behavior, and clinical psychology traditionally has been concerned with "abnormal" or "pathological" social and interpersonal behavior, the differences between the fields depend largely on our ability to draw distinc-

tions between normal and abnormal behavior. As discussed below, research strongly suggests that this distinction is difficult, if not impossible, to draw. The field of social psychology has become more difficult to define as social psychologists have become more concerned with topics traditionally viewed as "clinical" (e.g., the cognitive and interpersonal aspects of depression and anxiety). In addition, the field of clinical psychology has become increasingly difficult to define over the past several decades as we have learned more about the generality of psychological change processes, the relationship between normal and maladaptive development, and the continuity between "normal" and "abnormal" and between healthy and unhealthy psychological functioning.

A HISTORY OF THE INTERFACE BETWEEN SOCIAL AND CLINICAL PSYCHOLOGY

For most of the 20th century, social and clinical psychology remained separate enterprises. Not only were they concerned with what seemed to be different human phenomena (normal social behavior vs. psychological disorders), but they also employed different methods of investigation (controlled experiments vs. case studies). Philosophical and conceptual differences hindered attempts to bridge the two disciplines. Although these differences remain today, to some degree, since the late 1970s theorists and researchers from both sides have focused more on the commonalities between social and clinical psychology than on the differences. The result has been a wealth of conceptual and empirical articles, chapters, and books that have attempted to describe and empirically explore an interpersonal and cognitive approach to understanding psychological adjustment and to developing psychological interventions.

The term *clinical psychology* was first used by Lightner Witmer (1907/1996), who founded the first psychological clinic in 1896 at the University of Pennsylvania. Witmer and the other early clinical psychologists worked primarily with children who had learning or school problems. These early practitioners were influenced more by developments in the new field of psychometrics, such as tests of intelligence and abilities, than by psychoanalytic theory, which did not begin to take hold in American psychology until after Freud's visit to Clark University in 1909 (Korchin, 1976). Soon after Freud's visit, however, psychoanalysis and its derivatives came to dominate not only psychiatry but also the fledgling profession of clinical psychology. During most of the first half of the 20th century, psychoanalytic and derivative psychodynamic models of personality, psychopathology, and psychotherapy were the predominant perspectives. By midcentury, however, behavioral voices (e.g., Skinner; Dollard & Miller) and humanistic voices (e.g., Carl Rogers) were beginning to speak.

The two World Wars greatly hastened the development of the practice of clinical psychology. During World War I, psychologists developed group intelligence tests, which were needed by military services to determine individual differences in abilities. Woodworth developed his Psychoneurotic Inventory to identify soldiers with emotional problems (Korchin, 1976). Clinical psychology was given an even bigger boost by World War II because of the unprecedented demand for mental health services for military personnel during and after the conflict (Korchin, 1976). Of particular concern was the treatment of "shell shock," which had become recognized by the early 1920s as a psychological response to stress (Reisman, 1991). In the mid-1940s, the Veterans Administration recognized clinical psychology as a

health care profession, and this recognition spurred the development of doctoral training programs in the field. By 1947, 22 universities had such programs, and by 1950, about half of all doctoral degrees in psychology were being awarded to students in clinical programs (Korchin, 1976). In 1946 Virginia became the first state to regulate the practice of psychology through certification.

In 1949 a conference on the training of clinical psychologists was held at Boulder, Colorado (Maher, 1991). An outgrowth of earlier reports by APA committees in 1945 and 1947, it included representatives from the APA, the Veterans Administration, the National Institute of Mental Health, university psychology departments, and clinical training centers (Raimy, 1950). At this conference, the concept of the clinical psychologist as a *scientist-professional* or *scientist-practitioner*—first developed in 1924 by the APA's Division of Clinical Psychology—was officially endorsed. According to the new standards, a clinical psychologist was to be a psychologist and a scientist first and a practicing clinician second. Clinical programs were to provide training in both science and practice. Clinical practitioners were to devote at least some of their efforts to the development and empirical evaluation of effective techniques of assessment and intervention. However, the integration of research and clinical work often has been more an ideal than a reality. For example, a 1995 survey (Phelps, Eisman, & Kohout, 1998) found that less than one-third of practicing psychologists bother to measure treatment outcome. A more recent survey (Boisvert & Faust, 2006) found that, despite the increasing emphasis over the past decade on empirically supported treatments and evidence-based practice (APA, 2006), practicing psychologists in general have only a "modest familiarity with research findings" (p. 708).

When the scientist-practitioner model was adopted, social psychology was a required part of the training of clinical psychologists and remains so today. Several social cognitive and interactional approaches to personality and adjustment were available during clinical psychology's early years, including the theories of Julian Rotter (1954), George Kelly (1955), Harry Stack Sullivan (1953), and Timothy Leary (1957). Despite these alternatives, clinical psychology remained, for the most part, wedded to psychoanalytic notions. Social psychology had a limited influence on clinical practice because the academic training of clinical students took place in universities, whereas their clinical skills training (in particular, their internships) occurred mostly in psychiatric hospitals and clinics. In these setting, clinical psychologists worked primarily as psychodiagnosticians under the direction of psychiatrists, whose training was primarily biological and psychoanalytic. Therefore, despite required exposure to social, cognitive, and interpersonal frameworks, clinical psychology adopted the individualist, intrapsychic, and medical–biological orientations of psychiatry rather than an interpersonal and contextual orientation grounded in social psychology (Sarason, 1981).

By midcentury the practice of clinical psychology had become characterized by at least four assumptions about the scope of the discipline and the nature of psychological adjustment and maladjustment. First, clinical psychology is the study of psychopathology. That is, clinical psychology is concerned with describing, understanding, and treating psychopathology—deviant, abnormal, and obviously maladaptive behavioral and emotional conditions. Psychopathology is a phenomenon distinct from normal psychological functioning and everyday problems in living. Clinical problems differ in kind from nonclinical problems, and clinical populations differ in kind from nonclinical populations.

Second, psychological dysfunction is analogous to physical disease. This medical analogy does not hold that psychological dysfunctions are caused by biological dysfunctions,

although it does not reject this possibility. Instead, it holds that painful and dysfunctional emotional states and patterns of maladaptive behavior, including maladaptive interpersonal behavior, should be construed as symptoms of underlying psychological disorders, just as a fever is a symptom of the flu. Therefore, the task of the psychological clinician is to identify (diagnose) the disorder (disease) exhibited by a person (patient) and prescribe an intervention (treatment) that will eliminate (cure) the disorder.

Third, psychological disorders exist in the individual. Consistent with both intrapsychic and medical orientations, the locus of psychological disorders is *within* the individual rather than in his or her ongoing interactions with the social world.

Fourth, the primary determinants of behavior are intrapersonal. People have fixed and stable properties (e.g., needs or traits) that are more important than situational features in determining their behavior and adjustment. Therefore, clinical psychologists should be concerned more with measuring these fixed properties (e.g., by intellectual and personality assessment) than with understanding the situations in which the person functions.

An early union between social and clinical psychology was attempted in 1921 when the *Journal of Abnormal Psychology*, founded by Morton Prince in 1906, was transformed into the *Journal of Abnormal and Social Psychology*. Clinical psychologist Prince (the journal's editor) and social psychologist Floyd Allport (its managing editor) envisioned an integrative journal that would publish research bridging the study of normal interpersonal processes and abnormal behavior. The vision, however, did not become a reality. In the revamped journal's first two decades, few of its articles dealt with connections between social and abnormal psychology (Forsyth & Leary, 1991). The social psychological research published by the journal became increasingly theory-driven, whereas the clinical research was primarily professional in nature and usually had little relevance to theory (Hill & Weary, 1983).

The failure of this early attempt at integration is not surprising in light of the different paths taken by social and clinical psychologists during this time. Clinical psychology was developing as a discipline with scientific ambitions, but it continued to be dominated by psychodynamic perspectives that did not lend themselves to empirical testing and that emphasized the individual's inner life over interpersonal, situational, and sociocultural influences. For example, despite the best efforts of Kurt Lewin and the Yale Institute of Human Relations (IHR) group, psychoanalysis resisted efforts to be integrated with research-based general psychology. Maher (1991) wrote that, in the 1950s, "as a contributing discipline to psychopathology, psychoanalysis was scientifically bankrupt" (p. 10). At the same time, social psychology, however, was becoming more rigorously empirical and experimental, and thus increasingly irrelevant to the practice of clinical psychology.

Thus, by the 1950s, social psychologists and clinical psychologists were pursuing different paths that rarely crossed, even in the journal devoted to their integration. The questions raised by social psychologists focused largely on the situational determinants of normal social behavior and the cognitive constructions of presumably normal people. The questions raised by clinical psychologists dealt with the intrapsychic determinants of abnormal behavior (psychopathology) and the treatment of clinical disorders. Social psychologists conducted research from a nomothetic perspective that attempted to develop and test elementary principles of social behavior. Practicing clinical psychologists typically employed an idiographic approach with their clients and were concerned with what works with what client and what problem and were less concerned with trying to determine the independent influences of these various factors that seemed to explain a client's problems and of the various strategies

that seemed to work. Social psychologists were concerned with the discovery of general principles of social behavior through the use of objective and empirical methods and the analysis of group data. Clinical practitioners were concerned with the subjective experiences of individual clients and with using their own subjective experiences as a tool for understanding clients. Social psychologists were concerned with quantitative descriptions of people; clinical psychologists' descriptions of people were largely qualitative. Finally, social psychologists emphasized internal validity through controlled experiments. Clinical psychologists preferred naturalistic research with high external and ecological validity (Leary & Maddux, 1987).

As a result of these differences, Prince's experiment in social–clinical integration was aborted in 1965 when the *Journal of Abnormal and Social Psychology* was split into *Journal of Abnormal Psychology* and the *Journal of Personality and Social Psychology*. Thirty years later it was remarked that "no act better symbolizes the increasing specialization and fragmentation of psychological science" than this dissolution (Watson & Clark, 1994, p. 3). Like its predecessor, even the new *Journal of Personality and Social Psychology* gave first billing to the traditional study of fixed properties of the individual and second billing to the study of the individual's social world.

Despite this split, some social, clinical, and counseling psychologists continued to pursue integration. As noted previously, clinical psychology began to be influenced by learning theory and research (Dollard & Miller, 1950; Rotter, 1954). Many clinical psychologists, however, were skeptical of the animal-conditioning models on which learning theories were based, and so the influence of these models was limited. In the 1960s several attempts were made to construct connections between social psychology (as opposed to learning theory) and clinical psychology. Frank (1961) argued that all psychological change—including faith healing, religious conversion, and psychotherapy—could be explained by a few basic interpersonal and cognitive processes, such as a trusting relationship with a helping person and positive expectations of help. Goldstein (1966) described the relevance to psychotherapy of research on expectancy, attraction, authoritarianism, cognitive dissonance, norm setting, and role theory. Goldstein, Heller, and Sechrest (1966) offered a social and cognitive analysis of the therapist–client relationship and group psychotherapy and interpreted resistance in psychotherapy as being similar to reactions against attempts at attitude change. Strong (1968, 1982; Strong & Claiborn, 1982) presented an analysis of psychotherapy and counseling as a social influence process and later conducted a program of research on interpersonal processes in psychotherapy. Carson (1969) described the role of disordered social interactions in the origin of psychological problems and argued that psychological difficulties are best explained by *inter*personal rather than *intra*personal processes. This theme was also central to Ullman and Krasner's (1969) influential abnormal psychology text.

Three publications in the 1970s contributed much to the definition of the emerging interface of social and clinical psychology. Two were chapters on social psychological approaches to psychotherapy (Goldstein & Simonson, 1971; Strong, 1978) in the first and second editions of the *Handbook of Psychotherapy and Behavior Change* (Garfield & Bergin, 1971, 1978). The third was a 1976 book by Sharon Brehm that focused on the clinical implications of the theories of reactance, dissonance, and attribution. Since 1976, social and clinical research on the first two theories has declined, but research on attributions has flourished, such as research on the role of attributions in depression (see Riskind, Alloy, & Iacoviello, Chapter 15, this volume). The wave of interest sparked by these publications continued into the 1980s with work on the interpersonal origins of psychological problems, interpersonal

approaches to psychological assessment, and interpersonal influence in psychotherapy (Leary & Miller, 1986; Maddux, Stoltenberg, & Rosenwein, 1987; Weary & Mirels, 1982). At the same time, social psychological researchers increasingly studied topics of clinical relevance, such as self-concept, self-regulation, persuasion, and cognitive processes in a variety of psychological problems, as is evident throughout this volume.

A milestone in the development of a more "social" clinical psychology was the publication of the of the first issue of the *Journal of Social and Clinical Psychology* in 1983. Founded by social psychologist John H. Harvey, this new journal provided an outlet specifically for research at the interface of social and clinical psychology. A few years later, Brehm and Smith's (1986) chapter in the third edition of the *Handbook of Psychotherapy and Behavior Change* (Garfield & Bergin, 1986) broadened the perspective offered in Strong's 1978 chapter. (Unfortunately, the most recent edition of this handbook does not include a chapter on social psychological approaches.) An *American Psychologist* article by M. Leary and Maddux (1987) provided a set of basic assumptions for the social–clinical interface and summarized the major developments and issues in the field. The *Handbook of Social and Clinical Psychology: The Health Perspective* (Snyder & Forsyth, 1991) provided the most comprehensive compendium at that time of the application of social psychological theory and research to clinical issues and problems. More recent but less comprehensive volumes include *Social Cognitive Psychology: History and Current Domains* (Barone, Maddux, & Snyder, 1997) and Kowalski and Leary's *The Social Psychology of Emotional and Behavioral Problems* (2000) and *Key Readings in Social-Clinical Psychology* (2003).

In tandem with the publications noted above, professional developments during the past several decades have led to a greater awareness and appreciation by social and clinical psychologists of each others' work and greater opportunities for collaboration.

First, counseling psychology established itself as a field specializing in normal adjustment problems rather than severe psychopathology, and it shifted gradually from intrapsychic to interpersonal models (Tyler, 1972). As a result, counseling psychologists found many concepts and models in social psychology compatible with their approaches to understanding adjustment and psychological interventions. Many important studies on crucial psychotherapy issues, such as therapist–client matching, therapist credibility, the client–therapist relationship, and interpersonal influence, have been published in the past several decades in counseling psychology journals. Clinical psychologists interested in these issues were thus exposed to many psychotherapy-related studies based on social psychological models and concepts.

Second, behavior therapy, the part of clinical psychology most closely linked with general experimental psychology, became more cognitive. A glance at any recent clinical journal or book with *behavior* or *behavioral* in the title provides evidence of the cognitive evolution of behavioral clinical psychology. In fact, behavior therapy became so "cognitive" that several years ago the Association for the Advancement of Behavior Therapy changed its name to the Association for Cognitive and Behavioral Therapy. Cognitive and cognitive-behavioral psychotherapies, developed in the 1950s by psychoanalytically trained psychotherapists Albert Ellis and Aaron Beck, are concerned with many of the same basic issues of concern to social psychological theorists and researchers, such as the relationships among cognition, affect, and behavior and the impact of the situation on behavior. Cognitive-behavioral case formulations draw largely on social psychological principles and constructs. In fact, clinical

and counseling psychologists trained in cognitive-behavioral models may feel greater commonality with theorists and researchers in social psychology than with psychodynamic and humanistic clinical and counseling psychologists.

Third, the emergence and tremendous growth of health psychology expanded the traditional boundaries of both social and clinical psychology and provided a forum for the collaboration of researchers and practitioners from both areas. Basic theoretical questions about the relationship between emotional health and physical health and the practical problem of getting people to change their behavior in health-enhancing ways are ideal material for social–clinical collaboration. In fact, most health psychologists are social, clinical, or counseling psychologists who are interested in problems encountered in health and medical settings. The emphasis on health psychology extends beyond the traditional topics of psychopathology, and now much mainstream social psychology is concerned, once again, with understanding and solving important human problems.

Fourth, social psychology has changed in ways that have moved it toward integration with clinical psychology. The "crisis of confidence" in social psychology about the ecological validity of its laboratory findings (Sarason, 1981) resulted in a renewal of interest in applied research and real-world problems. This crisis and renewal set the stage for the entry of social psychologists into the study of clinical problems and issues. Social psychological research increasingly has merged the study of cognitive processes with the study of emotional interpersonal processes and the self. Social psychologists have become more concerned with understanding *social cognition*—how people construe social situations and the effects of these construals on social behavior, as evidenced throughout this volume. The study of social cognition has become central to current approaches to understanding personality, individual differences, interpersonal behavior, and emotions (Fiske & Taylor, 2007; Moskowitz, 2004; Kross, Mischel, & Shoda, Chapter 20, this volume; Shadel, Chapter 18, this volume), as revealed in any recent issue of the *Journal of Personality and Social Psychology*, *Personality and Social Psychology Bulletin*, or the *Journal of Social and Clinical Psychology*. This cognitive evolution includes cognitive approaches to understanding relationships. The study of relationships has shifted from concern with bargaining between strangers in the laboratory to concern with real-life intimacy, love, and marriage. Much of this recent work involves the study of psychological adjustment and dysfunctional behavior. As a result, the relevance of social psychological theory and research to clinical theory, research, and practice has increased immensely, along with the collaborations of social and clinical psychologists.

Fifth, disorders of personality, as formal diagnostic categories, were introduced into the official nosology of psychiatric and psychology disorders with the publication of the third edition of the American Psychiatric Association's (1980) *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III). The inclusion of these categories reflects the notion that personality can be disordered or dysfunctional and is worthy of attention independent of the broad traditional clinical notions of neuroses (e.g., depressive disorders, anxiety disorders) and psychoses (e.g., the schizophrenic disorders; Millon, 1981). Of course, the very notion that we can separate personality into normal and abnormal types (disorders) and the notion that we can neatly categorize types of abnormal personalities are largely inconsistent with a social psychological perspective. However, the definition of this new general category and the diagnostic criteria for the various specific disorders rely heavily on the *interpersonal* (rather than the intrapersonal) manifestations of the individual's dysfunction.

Personality disorders are noted more for the disruption they cause in the individual's relationships and social world than for the inner turmoil of the individual. Thus, this new set of diagnostic entities gave a greater *official* recognition to the importance of the *social* aspects of psychological dysfunction than ever before.

Since the publication of the DSM-III, hundreds of studies have been published examining various aspects of personality disorders. Because of the emphasis on interpersonal functioning in these disorders, research in social psychology and personality has assumed a new and greater relevance to the understanding of psychological adjustment and dysfunction. For example, research on the relationship between "normal" personality and these personality "disorders" strongly suggests that so-called personality disorders are extreme variants of normally distributed dimensions of individual difference rather than disorders discontinuous with normal personality (e.g., Widiger, 2007). This research supports the notion that the study of normal interpersonal behavior and dysfunctional interpersonal behavior involves the study of essentially the same problems and processes.

ORIENTING PRINCIPLES

It has been over 40 years since the partitioning of the *Journal of Abnormal and Social Psychology* and the symbolic partitioning of social and clinical psychology. It also has been 25 years since the publication of the first issue of the *Journal of Social and Clinical Psychology*. During this time, clinical psychology has become more rigorously empirical while maintaining its focus on understanding psychological adjustment and problems in living; social psychology has become more concerned with psychological adjustment and problems in living while maintaining its empirical rigor. Thus have the fields come to complement one another both in content (what they study) and method (how they study it). Social psychological journals such as the *Journal of Personality and Social Psychology* and the *Journal of Social and Clinical Psychology* regularly publish studies that are relevant to clinical issues, and some clinical and counseling journals (e.g., *Cognitive Therapy and Research*, *Journal of Counseling Psychology*) publish studies that deal with basic social psychological processes.

The following set of implicit assumptions regarding the nature of psychological problems and their treatment, which can be gleaned from the work of numerous theoreticians and researchers over the past several decades, provides a foundation for the application of social psychology to clinical psychology.

Psychological Problems Are Interpersonal Problems

Behavioral and emotional problems are essentially interpersonal problems. The majority of people who seek psychological services do so because they are concerned about their relationships with other people. Common adjustment problems such as depression, anxiety, marital discord, loneliness, and hostility consist primarily of interpersonal beliefs and behaviors that are expressed in interpersonal settings and make little sense when examined outside an interpersonal context. This assumption does not deny that some psychological problems may have strong biological roots, but it affirms that even biologically based problems are influenced by interpersonal forces.

"Normal" Behavior Is Sometimes Dysfunctional

Because much of social psychological research and theory deals with how people misperceive, misattribute, and subsequently "misbehave" in their relations with others, much of social psychology involves the study of what Freud (1901/1965) called "the psychopathology of everyday life." Cognitive dissonance theory, reactance theory, and attribution theories, for example, each describes cognitive and motivational processes of normal people, processes that are often illogical, unreasonable, or biased and that lead to poorly reasoned decisions. Therefore, even "normal" social cognitions and their affective and behavioral consequences are sometimes dysfunctional. The clinical or counseling psychologist with an in-depth knowledge of the social cognition literature, especially the errors made by normal people in social perception and judgment, is likely to have a greater awareness of the normality of seemingly pathological thought and behavior. Because the terminology in social psychology is less pathological and less dispositional in connotation, such awareness should lead to a decreased tendency to overpathologize.

Social Norms Determine the Distinction between Normality and Abnormality

The distinction between normality and abnormality is essentially arbitrary and is the product of social norms that are derived from, and enforced in, social settings. Thus, understanding how attitudes and beliefs become norms, how they change and how they are acquired and enforced, is essential to understanding how and why certain behaviors (including those with biological etiologies) are viewed as abnormal and others are not.

Abnormal Social Behaviors Are Distortions of Normal Behaviors

The vast majority of so-called abnormal social behaviors are essentially distortions or exaggerations of normal patterns that are displayed at times and in places considered by others to be inappropriate. Thus, many behaviors given pathological labels are governed by the same interpersonal processes that determine behaviors that escape the stigma of being labeled as deviant.

Clinical Judgment Involves the Same Processes as Everyday Social Judgment

Clinical judgment is a process of social cognition and person perception that involves the same processes as everyday social and person perception. Most important, clinicians make errors in clinical judgment that are similar to errors made by nonclinicians in nonclinical contexts (Leary & Miller, 1986). Thus, the study of social inference, problem solving, and decision making is crucial to understanding clinical assessment and diagnosis (e.g., Garb, Chapter 16, this volume.)

Clinical Interventions Focus on Social Cognitions

Most, and possibly all, clinical interventions, regardless of theoretical foundation, focus on changing what people think about, how they feel, and how they behave toward oth-

ers. Marital therapy, family therapy, parenting skills training, assertiveness training, social skills training, interpersonal and cognitive therapies, and other interventions are concerned primarily with helping people get along with other people and feel better about their interpersonal relationships. Indeed, most clinical and counseling psychologists trained in the last 20 years or so (i.e., those trained in social learning or cognitive-behavioral models) are essentially "applied social psychologists" in the sense that they are concerned with the reciprocal interactions of social cognitions (attitudes, self-beliefs, attributions, expectancies), emotion, and behavior.

Psychotherapy Is a Social Encounter

Psychotherapy, counseling, and other behavior change strategies, either dyadic or group, are interpersonal encounters, first and foremost, albeit social encounters with a specific goal—one person trying to help another. This assumption dictates that the foundation for psychological intervention is an understanding of interpersonal behavior, particularly relationship development and interpersonal influence processes (e.g., Brehm & Smith, 1986; Strong & Claiborn, 1982).

Social Psychological Theories Provide a Basis for Models of Behavior Change

Successful psychotherapy and behavior change strategies, regardless of theoretical foundation, have in common a relatively small number of features that explain their effectiveness (Frank, 1961). Because they propose general explanations for a broad range of human behavior, social psychological theories can provide the foundation on which to build an inclusive and comprehensive model of therapeutic behavior change.

OVERVIEW OF BOOK

This book deals with the three basic challenges that confront clinical and counseling psychologists: (1) understanding the causes of psychological problems, (2) evaluating and assessing psychological problems, and (3) designing effective interventions for ameliorating them. The chapters are organized not around psychiatric diagnoses (e.g., depression, anxiety, personality disorders) but around social psychological theories and concepts. Each chapter focuses on an important social psychological theory or concept that can offer a fresh framework for addressing clinically relevant questions.

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