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Clinical Sociology: What It Is and What It Isn't – A Perspective¹

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At this time, anyone in the country can claim to be a clinical sociologist without any challenge to that designation. Persons who already have chosen this title practice as one-to-one, group, family and addictions therapists, marriage counselors, hypnotists, teachers, gerontologists, sociometricians, organizational and community consultants. What currently distinguishes this wide-ranging collectivity is that most have a doctorate or a master's degree in sociology and many have left full-time academic work. Many have only recently become aware of the others.

Because of this range of practice, it is necessary to explore what clinical sociology is and what it isn't. Any attempt at definition is a thankless task because no definition currently can exclude anyone from choosing this designation. Yet at this time, attempts at clarification are important because clinical sociology is emerging as a response to both employment and ideological conditions within the discipline of sociology.

Clinical sociology has existed as a concept for at least fifty years. Bands of applied sociologists have existed outside of academic settings for even longer. It is unclear whether this upsurge of interest is transitory, another fad to be added to the long list of short-lived sociological trends or is what we are witnessing and taking part in a major development which has altered and will continue to alter the practice of sociology for decades to come. Following W.I. Thomas' dictum that what people perceive to be real is real in its intent, it is clear that some persons believe that clinical sociology is an idea whose time has come. There is the Clinical Sociology Association, a recently announced clinical sociology journal, articles and issues of other journals (i.e., Rhoades, 1979; Straus, 1979a, b, and c; Powers, 1979)², an introductory textbook (Glassner and Freedman, 1979), an unknown number of people who are involved in the practice of what they have defined as clinical sociology, several budding graduate programs and several persons who have written to me on

stationery identifying themselves as clinical sociologists (and I have responded on similar stationery).

However, this development has created some anger and confusion within sociology. Applied sociology has not been viewed as prestigious within sociology and those with prestige, senior faculty at graduate departments, frequently have difficulty in understanding the issues that could lead to further legitimation of the clinical role of sociologists. Some persons in academic settings have difficulty associating with the Clinical Sociology Association whose leadership and much of whose membership do not have academic prestige. Yet academic job opportunities in sociology for the next decade are scarce and clinical sociology might be a way to create new and useful careers for sociologists thus maintaining academic enrollments.

Those actively involved in clinical sociology have a great deal of difficulty defining what clinical sociology is and what it is not and what constitutes clinical practice. This lack of clarity is probably deleterious to the growth and development of the field. On the other hand, given the range of therapeutic approaches available, is a definition of clinical sociological therapy useful in a world where almost anything goes, both in licensed professions and among practitioners working in unregulated areas? I believe strongly that now is the time to work on definitions because clarification is critical to the future dimensions of a field that offers considerable promise not only to persons trained in sociology looking for new vistas, but also, and more importantly, to clients. These clients may be group members, groups, organizations or communities who wish the benefit of the significant and distinct expertise that can be generated by contact with persons who can communicate the sociological perspective as it relates to their current problems.

I have been able to locate nine definitional statements about clinical sociology in the literature. There is considerable similarity among these definitions, but not every definer is dealing with the same issues. If presented in a certain order, the statements create a generalized view of clinical sociology.

Clinical sociology is the application of a variety of critically applied practices which attempt sociological diagnosis and treatment of groups and group members in the community (Glassner and Freedman, 1979:5) . . . An analysis of clinical procedure indicates that it has three main characteristics: 1. the attention of the investigator is focused on a "case", i.e., on a person presenting concrete problems; 2. it is a co-operative enterprise and enlists the aid of a number of specialists; 3. whatever may be the theoretical interests of the participants, clinical procedure has an immediate

therapeutic aim and includes, therefore, not merely a study of the "case", but the formulation of a program of adjustment or treatment (Wirth, 1931: 50) . . . Clinical sociology is the kind of applied sociology or sociological practice which involves intimate, sharply realistic investigations linked with efforts to diagnose problems and to suggest strategies for coping with these problems (Lee, 1979: 489) . . . Clinical sociology brings a sociological perspective to intervention and action for change. The clinical sociologist is essentially a change agent rather than a researcher or evaluator. Clients may be individuals, groups or organizations. The clinical task may involve, for example, a redefinition of the self, role, or situation. Clinical sociology uses a variety of techniques or methods for facilitating change. The field's value orientation is humanistic, holistic, and multidisciplinary (Glass, 1979: 513-4) . . . Clinical sociologists are change agents who use a sociological perspective as the basis for intervention. Many sociologists who teach are "clinicians" in that they try to foster changes in students' attitudes and/or behavior as a result of classroom experiences. (Fritz, 1979; 577) . . . Rather than adjust people to the "realities" of the "way things are" or "the system," we are committed to helping people cope with their sociocultural and historical situations and institutions and situations in the direction of self-determinism, human value and human dignity (Straus, 1972a: 480) . . . The sociologist, insofar as he has a point of view and method of approach to problems of personality and behavior, proceeds on the hypothesis that human beings everywhere live in social groups and that the conduct of the individuals, however it may differ from others, is always expressive of the culture of the groups (Wirth, 1931: 60) . . . The clinical sociologist, however, makes his own independent diagnosis of the client's problems. He assumes that the problems as formulated by the client may often have a defensive significance and may obscure, rather than reveal, the client's tensions (Gouldner, 1965) . . . The sociological approach requires the marital and family therapist to understand the conditions, values and relationships which characterize the real world of the society of the American Dream and which affect marital and family interaction. Conditions associated with American society include unemployment and job insecurity. Associated values include extreme individualism, success, racism and sexism; and associated relationships include aggressive competition and exploitation (Hurwitz, 1979: 557).

What themes emerge from this conglomeration? Clinical sociology is:

1. practice oriented
2. focuses on case studies
3. works with individuals, groups, organizations, and communities
4. diagnostic
5. change-oriented
6. humanistic
7. tries to comprehend the societal factors which restrict the individual from being effective
8. can move beyond the client's formulation of the problem to consider other factors that affect functioning, especially broad social trends
9. uses insights derived from immersion in the critical sociological tradition; uses sociological imagination
10. leads to behavior change and growth
11. tends to have a liberal/cynical or radical ideological cast.

Given what is known about working with people, their groups, organizations and communities, is such an approach valid? The answer is clearly yes. Is it the best possible approach? This is highly debatable. Is it an approach that is uniquely sociological? No!

One can also examine what clinical sociology is not. It is not:

1. academic
2. intrapsychic
3. biochemical
4. value-free
5. accepting of the ideological basis of the client's reality
6. culture-free
7. conservative
8. relying on a single ritualistic set of techniques to discover the key factors important in comprehending the situation under study.

The sociological tradition and a good sociological imagination can partially equip some sociologists to work as clinical sociologists. In the textbook, *Clinical Sociology*, Barry Glassner and I (1979) present a version of the necessary knowledge base for a clinical sociologist. This includes theoretical grounding in historical, systems, dramaturgical, conflict, and interactional approaches with the ability to develop alternative theoretical perspectives or integrate theoretical approaches; methodological grounding in the basic skills of

looking, listening, questioning, reporting and critical thinking, and how these skills are used as methods in participant observation, survey research, interviewing, and documentary analysis; substantive comprehension of ethnicity, stratification, aging, family and sex roles, social change and everyday metaphysics.

It is likely that most sociologists will be exposed to many of these subjects as part of their graduate education. In order to do clinical work such knowledge must become the basis of practice. One needs skills as the basis of competence with appropriate attitudes which place the knowledge and skills into an effective and appropriate action context. In most graduate sociological education, skills are taught, but these tend to be the academic skills of research. Such skills can prove helpful in clinical work, but they are not central.

Therefore, it is likely that persons who view themselves as clinical sociologists will have developed the skills that are the basis of their practice mostly outside of their formal sociological training. Because of the wide variety of clinical practice, the skills developed will vary in terms of the focus of the practice. Straus's distinction of micro and macro sociological foci is useful to determine focus. Our textbook delineated several techniques as a basis for sociological practice: catalyzing self-help groups, sociodrama and sociometry, organizational work, simulations, community work, asking embarrassing sociological questions.

For microsociologists whose practice resembles psychotherapy, the necessary skills include: accurate empathy, non-possessive warmth, and genuineness as Truax and Carkhuff (1967) outline these essentials. I would term these presentation of self skills. In addition, interpersonal communication skills are necessary. Gerald Goodman (1979) formulates these as questioning, advisement, silence, reflection, interpretation and self disclosure. Then there are intervention skills, described by Gottman and Leiblum (1974) as: deciding whom to see; finding out how the decision was made to come for treatment; administering a problem assessment; negotiating a therapeutic contract; setting objectives of initial change efforts; engineering these efforts; handling resistance; making treatment modifications; monitoring change; assessing impact and planning transfer of training, termination and follow-up; and finally, especially if the setting is a private practice, business administration skills.

For those involved in macroclinical sociology as a worker with organizations or communities, there still need to be presentation-of-self skills, communication skills and intervention skills, but they take somewhat different forms depending on the work situation. The scale is different--the skills have a

different nomenclature although the goal is still planned change but for greater numbers of people.

Just as microclinical sociology interventions can be viewed as for the empowerment of the client, so can macroclinical sociological intervention. For example, contrast Glidewell's (1976: 227-42) paradigm for induced social change with a psychotherapeutic change strategy. Its cycle consists of shared knowledge for ongoing activity leading to increased productivity and enhanced prospects leading to increased exports and imports to create new linkages, thereby bringing about an influx of strange ideas and practices leading to tension, confusion and disconfirmation that brings about either tension reduction through retreat to old forms or tension management to incorporate or pursue change. Or contrast the AVICTORY acronym of Davis (1978: 648-58) that raises key considerations for the development of any new program with psychotherapeutic intervention assessment:

- A. Do we have the ABILITIES --- the resources and capabilities?
- V. Does the new program match the VALUES --- the style and philosophy of our own institution?
 - I. What and where is the INFORMATION we need to consider before implementing the new program?
- C. What CIRCUMSTANCES must we consider --- the environment in which our agency exists?
- T. How's the TIMING? Is now the right time to do it?
- O. Is there an OBLIGATION to change? Why change at all?
- R. What RESISTANCES might we encounter?
- Y. What YIELDS can we expect from the change?

It has been my experience that effective work requires both micro and macro clinical sociological skills. When working with individuals you have to keep the broader issues of the society in focus; when working on broader issues of social change you have to keep in mind the effect on the individual. The approach of the College for Human Services in New York City (College for Human Services, 1976) successfully combines micro and macro empowerment. The eight modes of service provision which they teach link the micro with the macro. These are: assume responsibility for life-long learning; develop professional relationships with citizens and co-workers; work with others in groups; function as a teacher; function as a counselor; function as a supervisor; act as a change agent.

Each of these modes is examined in connection with five dimensions of effective service: the purpose of the service, the underlying values, the relationship between the self and others, the relationship to systems, and the skills

needed to deliver the mode. Students learn to perform constructive actions that empower citizens within each of the modes. (See Grant and Riesman, 1978: 135-76.)

However, the sociological knowledge base, combined with a chosen set of skills, is not sufficient to assure highly qualified clinical sociologists. Competence in a field moves beyond one's education, experience and technical skills to the quality of superior practice. The answer to the question, "What are the qualities of an especially competent clinical sociologist?" is quite different from the answer to the question, "What knowledge and skills does a clinical sociologist have?" The competence issue is quite important as psychologist Paul Pottinger (1979: 7) notes:

What is meant when it is said that a practitioner is competent? This seemingly innocuous question has wide ramifications and implications with regard to teaching, credentialing, regulation (e.g., licensing), and setting standards of program approval, third party payments, etc. Currently, we have a plethora of criteria and standards for education and for the regulation of workers that is based on political and economic incentives for defining what constitutes competence (and how it is taught and assessed).

No one profession or discipline has a monopoly of competent practitioners. No one training approach creates greater competence. Work of McBer and Company (Boyatzis and Burruss, 1977) has demonstrated that it is an attitudinal set that apparently distinguishes superior alcoholism counselors in the Navy from the average. The superior counselors had a much better success rate than the average ones. These attitudes clustered as follows:

One cluster appeared to describe a positive regard for people and a belief that a client can change and can be the director of (i.e., responsible for) that change . . .

The second cluster appeared to describe a desire for personal and professional growth, reflected in a counselor's willingness to seek help for himself and in a knowledge of his limitations . . .

The third cluster appeared to describe ego strength or ego maturity . . .

The fourth cluster appeared to describe the ability to think in terms of causal relationships, which enables a counselor to "see" patterns in a patient's behavior . . .

The fifth cluster appeared to describe the genuineness of a counselor, the ability to be congruent and consistent and to “be” in the present . . .

The sixth cluster appeared to describe a counselor’s ability to empathize with the client (i.e., a counselor’s verbal and nonverbal sensitivity) . . .

The seventh cluster appeared to describe a counselor’s ability to use various resources to help a patient.

These competencies certainly are not limited to a specific discipline or a single approach to training or service delivery. They are shared by competent practitioners from many professions in a multi-disciplinary world of practice --- a world from which sociology largely has been excluded, for as Louis Wirth (1931:52) correctly pointed out, “. . . the technicians who are on the ground floor at the time of organization tend to assume the control and formulate the policies of the enterprise.” This is clearly the situation in psychotherapy, but not yet the situation in organizational and community consultation.

The big four of psychotherapy are medicine (psychiatry), psychology, social work, and marriage and family counseling. We must examine the nature of the control they exert through policies that exist because this is the world with which the microclinical sociologist has to co-exist and be part of.

Each of these professional ideologies promulgates the position that there is a highly specific body of knowledge, skills and professional attitudes distinct and unique to that profession and only available to those deemed acceptable for membership and thereby allowed to be licensed or certified, use the professional trademark, and to earn a living using the specific professional appellation. Stronger (and frequently male dominated) professions enforce an apparent monopoly on professional service and with the power of the state behind them, punish those who dare to practice without a license. Such ideology separates the world of professional service into distinct pieces of the pie and minimizes the knowledge, skills, and attitudes shared in common among the psychotherapeutic professions.

The actual situation appears quite different. The public, the media, friends, family, and each of us daily practice psychotherapeutic professions without certification and even sometimes get paid for our efforts. We make medical decisions in choosing what we eat, drink, and what pills we take. We make psychological decisions when we try to motivate others, choose educational programs and examine perceptions. We make social work decisions, by referring persons for information and services.

Yet when such help-seeking breaks down or doesn't work we turn to others who we believe have been trained to deliver competent service and who work in professional arenas filled with strangers supported by actors in supporting roles. Frequently, because of inadequacies in their training, their professional ideology, their recognition that as a member of a professional club they can make considerable money without keeping up with their field, and because by seeking such help we put ourselves into the position of an inferior, many of these contacts are unpleasant and useless. At other times, we swear by the professionals we choose and do not swear at them.

When one examines the professional world even more closely, one discovers that instead of clearly defined, distinctly separate modalities, knowledge, attitudes and skills generally are shared across professional lines with each profession having a small distinct core unique to it. You would never know this from listening to most professional spokespersons, or by reading licensure laws.

One must contrast the multidisciplinary nature of psychotherapy with the professional attempts to limit its practice. One writer (Raimy, 1950) has stated that psychotherapy is "an undefined technique applied to unspecified problems with unpredictable results. For this technique rigorous training is required." A more professional, accepted definition is that of Jerome Frank (1973: 2-3):

We shall consider as psychotherapy only those types of influence characterized by:

1. a trained, socially sanctioned healer, whose healing powers are accepted by the sufferer and by his social group or an important segment of it;
2. a sufferer who seeks relief from the healer;
3. a circumscribed, more or less structured series of contacts between the healer and the sufferer, through which the healer, often with the aid of a group, tries to produce certain changes in the sufferer's emotional state, attitudes, and behavior. All concerned believe these changes will help him. Although physical and chemical adjuncts may be used, the healing influence is primarily exercised by words, acts, and rituals in which sufferer, healer, and - if there is one - group, participate jointly.

Note carefully that the process as described has no professional limitation upon it. However, the big four of psychotherapy each has tried not only to limit persons from using protected titles or descriptions of services, but also the practice of the skills associated with the title defined as primarily unique to that profession. For example, the American Psychological Association's model code for legislation (American Psychologist, 1979: 7) includes:

A person represents himself to be a psychologist when he holds himself out to the public by any title or description of services incorporating the words "psychology," "psychological," "psychologist," and/or offers to render or renders services as defined below to individuals, groups, organizations, or the public for a fee, monetary or otherwise.

The practice of psychology within the meaning of this act is defined as rendering to individuals, groups, organizations, or the public any psychological service involving the application of principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, thinking, emotions, and interpersonal relationships; the methods and procedures of interviewing, counseling, and psychotherapy; of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotion and motivation; and of assessing public opinion.

The application of said principles and methods includes, but is not restricted to: diagnosis, prevention, and amelioration of adjustment problems and emotional and mental disorders of individuals and groups; hypnosis; education and vocational counseling; personnel selection and management; the evaluation and planning for effective work and learning situations; advertising and market research; and the resolution of inter-personal and social conflicts.

Psychotherapy within the meaning of this act means the use of learning, conditioning methods, and emotional reactions, in a professional relationship.

In the actual legislation of some states certain professionals, including sociologists on a few occasions, are exempted from the law. Social work practice is defined in their model code (National Association of Social Workers, 1973) as:

The disciplined application of social work values, principles, and methods in a variety of ways includes but is not restricted to the following: (1) counseling and the use of applied psychotherapy with individuals, families, and groups and other measures to help people modify behavior or personal and family adjustment, (2) providing general assistance, information, and referral services and other supportive services, (3) explaining and interpreting the psychosocial aspects of a situation to individuals, families, or groups, (4) helping organizations and communities analyze social problems and human needs and provide human services, (5) helping organizations and communities organize for general neighborhood improvement or community development, (6) improving social conditions through the application of social planning and social policy formulations, (7) meeting basic human needs, (8) assisting in problem-solving activities, (9) resolving or managing conflict and/or (10) bringing about changes in the system.

The social work legislative code defines psychotherapy as follows:

“Psychotherapy” is the use of psychosocial and social methods within a professional relationship to assist a person or persons to achieve a better psychosocial adaptation; to acquire greater human realization of psychosocial potential and adaptation; to modify internal and external conditions that affect individuals, families, groups, or communities with respect to their behavior, emotions, and thinking and their intrapersonal and interpersonal processes. Forms of psychotherapy include but are not restricted to individual psychotherapy, conjoint marital therapy, family therapy, and group psychotherapy.

Marriage and family counselors define their service thus:

“Marriage and family counseling” means the rendering of counseling services or therapy to individuals, either singly or in groups, for the purpose of resolving emotional conflicts within marriage and family relationships, modifying behavior, altering old attitudes, and establishing new patterns in the area of marriage and family life including premarital counseling and post-divorce counseling.³

These definitions overlap and certainly restrict the practice of others who have been trained to work in these areas, including some sociologists. This defining of professional turf (by professional associations linked politically to licensure and third party payments manifestly to protect the public against dangerous uncertified practitioners) has made it difficult for those non-approved to practice. Some of the conclusions made by Daniel Hogan (1979: 344, 350) in his monumental work, *The Regulation of Psychotherapists*, are useful in this regard:

Empirical evidence indicates that those in the helping professions bring about similar results no matter what techniques are used, no matter what the purposes of their methods are, and irrespective of type of academic training. These facts suggest that past distinctions between therapy and other practices, such as encounter groups, may not have heuristic value. They also suggest that psychotherapy does not yet lend itself to easy or precise definition. Unfortunately, difficulties in operationalizing a definition of therapy have not kept proponents of rigid regulations from enacting licensing laws with broad definitions of practice encompassing activities previously thought of as being therapeutic.

The fundamental conclusion suggested by the preceding findings is that traditional modes of professional regulation have not done a particularly good job of protecting the public. Licensing boards, the courts, and professional associations are not likely to provide the forum in which effective regulation will take place, at least as traditionally conceived. The difficulties in adequately defining the nature of limits of psychotherapy, the lack of standards and criteria for determining what practices are harmful, and the lack of valid and reliable methods of selection exacerbate all the problems associated with traditional forms of professional regulation. If the public is not protected --- and there is little doubt that it should be --- and if regulation is not to have serious negative side effects, then the development of an alternative model and the improvement of existing methods are necessary.

It is a bitter paradox that the skills necessary to be exemplary as a practitioner, the nature of psychotherapeutic practice, the potentially rich contributions that those with sociological training can make in helping clients are being limited by the powerful ideologies of professional associations which control important aspects of practice.

Yet sociology, even as a latecomer, is not excluded from the world of psychotherapeutic practice. One must be quite specific on the exclusion. Anyone can practice clinical sociology privately or publicly providing one does not describe oneself or perhaps one's work in terms that are protected. However in most settings, one would not be viewed with the same legitimacy as members of those other professions, one can not get third party payments and this usually means that one cannot charge the same hourly rate. However, if you are an exemplary psychotherapist, you will make it as a clinical sociologist.

In reviewing what has been presented up to now, it is clear that one can easily get caught in just examining the relationship of clinical sociology to the contemporary worlds of professional practice. Such an examination is necessary if clinical sociology is to develop. Clinical sociology could belong as an appropriate modality in the worlds of practice as there is a rich sociological knowledge base, methods of practice that can be derived from this base, and the potential for highly competent practitioners. On the other hand, there are a few clinical techniques that are only available to clinical sociologists. Many clinical sociological activists are placing their attention just on the right to be professionally recognized and to make a good living.

If this is the only outcome of the professional energy of clinical sociologists, then an important opportunity will have been lost. While the multidisciplinary worlds in which clinical sociologists are striving for legitimacy can claim many successes, there are still groups, group members, organizations, communities, and societies who have received ineffectual services through existing strategies of practice. Clinical sociologists now have the opportunity to move beyond contemporary strategies of change agency to confront anew the society of the eighties and its resonances for those who could be helped by an emerging clinical discipline not fettered by a practice ideology rooted in the past. Such a confrontation has to be part of clinical sociologists' dialogue if it is to be more than just one of many indistinguishable shepherds to the large flock of those in need.

A new confrontation could begin with a critical examination of the contemporary world of multidisciplinary practice. Current multidisciplinary practice works for those who are motivated to change and who have access to economic opportunities. Contemporary practice tends to be much less successful for persons, organizations, and communities that are poor or impoverished, apathetic, chronically impaired, or stigmatized. Furthermore, current multidisciplinary practice usually intervenes at either the micro or macro level while multiple level interventions would be, frequently, more successful. A clinical sociologist is more likely to think in ways that relate the in-

dividual to the roles undertaken in groups, organizations and communities. Thinking through interventions based on such relationships suggest some new forms for practice.

Sociologists tend to have early knowledge of emerging social problems. Can clinical sociologists develop specific intervention strategies that relate to problems which are emerging, aiding in empowering those who are potential victims of these problems?

Some analysts of contemporary society have noted the breakdown of the socializing functions of many social institutions. Could clinical sociologists aid in the development of new approaches to socialization? Can clinical sociological efforts involve planned change leading to a new social order?

Organizational development in management settings has begun to comprehend that the worker who as a member of a team has been given decision-making options in production and quality control frequently is a more productive worker. Could clinical sociologists play significant roles in humanizing the workplace and improving the quality of work life? There are fascinating roles for clinical sociologists in the workplace involving management, unions, and workers; this is an area where no profession has a monopoly.

Throughout the human services, at this time, there is a great paucity of innovative ideas. Could clinical sociologists provide a new spark?

Through critical examination of any problem area of the society, a clinical sociologist can discover situations in which the application of a variety of critically applied practices which attempt sociological diagnosis and treatment of groups and group members in the community can lead to exciting approaches to practice --- practice that no other profession is attempting.

This strategy can be entitled "if you can't join them as an equal, beat them" --- beat them by being smarter, by being more innovative, by entering difficult situations in which the establishment fears to tread, by attempting new solutions and delivering what you attempt. Historically, this has been a successful approach for new arrivals on the block. It is my belief that it will work again. This opportunity is what excites me about the potential of clinical sociology and I hope it excites you too.

NOTES

1. Presented at the 30th annual meeting of the Society for the Study of Social Problems to a joint session of the Psychiatric Sociology Division and the Clinical Sociology Association, August 25, 1980.
2. Also, Glassner's (1981) article and the critical comments which follow it.
3. All the model licensing legislation and state-by-state rundown of actual legislation are summarized by Hogan (1979).

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