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Clinical sociology is the creation of new systems as well as the intervention in existing systems for purposes of assessment and/or change. Clinical sociologists are humanistic scientists who are multi-disciplinary in approach. They engage in planned social change efforts by focusing on one system level (e.g., interpersonal small group, organization, community, international), but they do so from a sociological frame of reference.

Clinical Sociology Review publishes articles, essays, and research reports concerned with clinical uses of sociological theory, findings or methods, which demonstrate how clinical practice at the individual, small group, large organization or social system level contributes to the development of theory, or how theory may be used to bring about change. Articles in the Review are generally expected to be relevant to intervention at some level. Articles may also be oriented to the teaching of clinical sociology. Shorter articles discussing teaching techniques or practice concepts may be submitted to the Teaching Notes Section or Practice Notes Section. Manuscripts will be reviewed both for merit and for relevance to the special interests of the Review. Full length manuscripts should be submitted to the Editor, Susan Brown Eve, Department of Sociology and Social Work, POB 13675, University of North Texas, Denton, TX 76203, (817) 565 2054 Teaching Notes should be submitted to the Teaching Notes Section Editor, Sarah Brabrant, Department of Sociology, POB 40198, University of Southwest Louisiana, LaFayette, LA 70504, (318) 235 7656. Practice Notes should be submitted to the Practice Notes Section Editor, H. Hugh Floyd, 426 Atherton Drive, Metairie, LA 70005, (504) 286-6301.

Manuscript submissions should follow the latest American Sociological Association style guidelines, including reference citation style, and should include an abstract. Suggested length for full length manuscripts is 20 pages double spaced, and for Teaching or Practice Notes, eight pages double spaced. There is a $15.00 processing fee which is waived for members of the Sociological Practice Association. Send four copies of the manuscript to the appropriate editor. Final copies of manuscripts should be sent on a 5 1/4 inch IBM compatible disk, either in ASCII or a standard word processor text, preferably Word Perfect.

Books for consideration for review in the *Clinical Sociology Review* should be sent directly to the book review editor. Harry Cohen, Department of Sociology, Iowa State University, Ames, IA 50011; (515) 294-3591.

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Correction: in *Clinical Sociology Review*, Vol. 9, "Combining Sociology and Epidemiology," pp. 87-105, the first author, Thomas Sachs Plaut, was listed as Thomas W. Plaut. The Editorial Board apologizes to Prof. Plaut for this error. The other authors, Suzanne Landis and June Trevor, were listed correctly.

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CLINICAL SOCIOLOGY REVIEW

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Contents

Editor's Preface

This is the tenth issue of the *Clinical Sociology Review*. It is an exciting issue with which to mark the first decade of *CSR*'s existence. It begins with a reprint of an inspiring article by **Harvey Zorbaugh** entitled "Sociology in the Clinic," in the **History of Clinical Sociology** section, edited by **Jan M. Fritz**. Originally published in 1939 in *The Journal of Educational Sociology*, the article traces the roots of clinical sociology at the University of Chicago, and the author advocates greater use of the clinic by sociologists as a way of enriching theory and teaching. In his stirring Presidential Address from the 1991 annual meeting of the Sociological Practice Association in Costa Mesa, California, **Phillip D. Robinette** exhorts sociological practitioners to overcome the profession's mid-life crisis and to regenerate the organization with their individual and collective energy and enthusiasm.

The articles appearing in this issue appropriately reflect a range of issues and concerns from the micro, meso and macro levels of society. The authors include professional clinical sociologists and sociological practitioners working both in practice settings and in academia. The first article, "Integrating Psychodynamic, Cognitive, and Interpersonal Therapies: A Biophysical Role Theory," by **Tamara Ferguson**, **Jack Ferguson** and **Elliot D. Luby**, presents the results of an interdisciplinary effort by two sociologists and a psychiatrist to develop a theoretical model of stress that can be used to structure interview schedules to help patients and families identify problems and work for their solutions. In "Understanding Paranoia: Toward a Social Explanation," by **David May** and **Michael P. Kelly**, the authors use a detailed case history to argue that

paranoia is not so much a disease as a logical outcome of social stress and lack of integration into a social network. In her article, "Deep Learning Groups: Combining Emotional and Intellectual Learning," **Valerie Malhotra Bentz** uses a case study of two small group seminars to illustrate how "deep learning" can be used therapuetically to promote the maturation of clients. These three theoretically based articles by practicing counseling sociologists greatly inform the practice of clinical sociology.

The next three articles deal with the specific issue of chemical dependency and the relevance of sociology to understanding and treating this problem. In "Using Sociology to End Chemical Dependency," **J. Barry Gurdin** describes a methadone treatment program in which he is a counselor. He examines the advantages of methadone maintenance in combination with other therapies to resocialize heroin addicts. **John E. Glass** argues that problematic human behavior has social origins, and that those origins have implications for intra-personal therapuetic interventions, as well as for interpersonal interventions, in his article, "An Alternative Understanding of the Cognitive, Emotional, and Behavioral Characteristics of Individuals Raised in Alcoholic Homes: A Clinical Theory of the Individual." In "Intervention Among Children of Substance Abusers and School Success," **Marguerite E. Bryan** evaluates the effectiveness of an intervention program for African-American high school students who are children of alcoholic parents. She concludes that the program is effective in reducing absenteeism and improving grades among these students.

When clients are in therapy, they are engaged in a dynamic, interpersonal interaction with their therapists. As the next two articles in this issue demonstrate, these interactions may take some unexpected turns. In "Cross Cultural Intervention III: Some Corrections and an Update in the Case of Hexed Hair," the client, **Sophie Koslowski**, joins forces with the therapist, **Jonathan A. Freedman**, to update her case and to correct the therapist's errors in previous reports of the case. This act of authorship is an empowering action by the client. In the following article, "Identification of Violence in Psychiatric Case Presentations," **Edward W. Gondolf** and **Joyce McWilliams** find that psychiatrists tend to neglect and minimize violence in the lives of psychiatric patients, and suggest that clinical protocols be designed to give more consideration to these kinds of social problems. In these articles, clinical sociologists offer insights into the social organization of the therapeutic encounter, as well as the treatment technique.

The last four articles treat problems in social institutions. The first two of these focus on problems in the family. In "Comparing the Psychological Impact of Battering, Marital Rape, and Stranger Rape," **Nancy M. Shields**

and **Christine R. Hanneke** find that marital rape victims score higher on indices of paranoid ideation and psychoticism than do victims of battering or of stranger rape. **Diana J. Torrez**, in "Sudden Infant Death Sydrome and the Stress-Buffer Model of Social Support," reports that participation in a support group to facilitate the grieving process is beneficial for families who suffer the loss of an infant.

In "Taking Back a Rich Tradition: A Sociological Approach to Workplace and Industrial Change in the Global Economy," **Marvin S. Finkelstein** advocates increased participation by clinical sociologists in the movement toward flexible and participatory involvement in the workplace. Finally, **Randy Stoecker** and **David Beckwith**, in "Advancing Toledo's Neighborhood Movement Through Participatory Action Research: Integrating Activist and Academic Approaches," discuss the increasingly important role of participatory research and the problems of integrating the roles of activist and researcher.

In this issue, the Editorial Board introduces a new section, **Teaching Notes**, edited by Sarah C. Brabrant. This section contains shorter articles that focus on teaching clinical sociology at the graduate and undergraduate levels. The two articles which appear in the section will, we hope, inaugurate a new tradition in the journal. In "Techniques for Imparting Clinical Knowledge in Nonclinical Courses," **Mary Sengstock** discusses the use of case histories and personal analogies to teach clinical content to her gerontology students. **Joao Teixeira** discusses the use of drama to teach sociology in his article, "Theater as a Teaching Procedure in Sociology."

Like the articles, the books reviewed in this issue range from the micro to the macro levels of society. The first is the long-awaited *Handbook of Clinical Sociology*, edited by Howard M. Rebach and John G. Bruhn, and reviewed by **Stanley S. Clawar**. The book contains chapters on the role of clinical sociology, general practice concerns, examples of clinical sociology in a variety of settings, and the relevance of clinical sociology for special populations, including women and minorities. *Clinical Intervention for Bereaved Children: A Hospice Model*, by Elizabeth J. Clark, Grace C. Zambelli, Anne de Jong and Karen Marse, is reviewed by **Robert Fulton**. This book is a manual for bereavement intervention. *Be an Outrageous Older Woman— A RASP* — * A Remarkable Aging Smart Person*, by Ruth Harriet Jacobs, and reviewed by **Gladys Rothbell**, exhorts older women to demand what is due them and provides tips for enjoying old age. **James A. Kitchens** reviews two books, *Violent Emotions: Shame and Rage in Marital Quarrels*, by Suzanne M. Retzinger, and *Psychiatric Response to Family Violence: Identifying and Confronting Neglected Danger*, by Edward W.

Gondolf. Ms. Retzinger argues that marital conflict threatens an important social bond, and that this threatened loss creates shame and alienation, which, if denied, lead to anger. Understanding the process has implications for intervention. Dr. Gondolf's book is a description of the limitations of psychiatric responses to family violence. Finally, *The Rich Get Richer: The Rise of Income Inequality in the United States and the World* by Denny Braun, and *Assets and the Poor: A New American Welfare Policy*, by Michael Sherraden, reviewed by **Josephine Ruggiero** and **Eric Hirsch**, focus on the problem of economic inequality.

This issue is the result of my first year of work as the Editor of *CSR*. I would like to thank the members of the Executive Board, chaired by the President, Phillip D. Robinette, for giving me the opportunity to serve the discipline of sociology in this way. It has been a rewarding experience and I look forward to the remaining two years of my term. I would like to thank David J. Kallen, Editor from 1986 to 1991, for his assistance in the transition. His sage advice, based on six years of experience, was invaluable and helped me to avoid many pitfalls. I would also like to thank Elizabeth J. Clark, Consulting Editor, Jan M. Fritz, Historical Section Editor, and Julie Loehr, of Michigan State University Press, for their advice and encouragement. Others deserving special praise in this issue are Harry Cohen, Book Review Editor, and Sarah Brabrant, Teaching Notes Editor, for their conscientious and aggressive work in preparing their respective sections. I greatly appreciate the work of all the members of the Editorial Board, who are listed elsewhere, and I look forward to an even closer working relationship in the future. The sixty-one reviewers are also to be praised for their thorough and punctual reviews. Without their assistance, the journal could not function. Ms. Margaret Higgins, a graduate student in Sociology at the University of North Texas, served as the Editorial Assistant during the past year. Her impeccable organizational skills were invaluable in getting the journal off to a good start in its new home. Finally, I am grateful for the support, financial and otherwise, that I have received from the administration at the University of North Texas, including Clifford M. Black, a clinical sociologist and Associate Dean of the School of Community Service; Blaine A. Brownell, a historian and Provost and Vice President for Academic Affairs; and Daniel M. Johnson, a sociologist and Dean of the School of Community Service. Without the support of these three progressive social scientists/administrators, we could not support the journal in the Department of Sociology and Social Work.

About the Authors

Valerie Malhotra Benz is currently program director at the Fielding Institute in Santa Barbara, California. She is co-editor of Visual Images of Women in the Arts and Mass Media, and is the autthor of numerous journal articles. She is the author of *Becoming Mature: Childhood Ghosts and Spirits in Adult Life*, published by Aldine de Gruyter in 1989.

Marguerite Bryan is currently Executive Director of the New Orleans Education Intervention Center, a not-for-profit alcohol and other drug abuse prevention agency based in the inner city of New Orleans, Louisiana. She has been working in applied settings as administrator of comunity social outreach agencies over the last 10 years, including her current position where she has been for seven years. She is currently following up further research in the area of substance abuse prevention and social action program evaluation.

Tamara Ferguson is adjunct associate professor of sociology in psychiatry at Wayne State University School of Medicine. She is teaching the staff at Harper Day Treatment Center how to use a biopsychosocial role theory, a theory of alternatives, to interview and treat mental patients.

Jack Ferguson is professor of sociology at Windsor University. He is completing a survey on the social services needs of Francophones in a regional area in Canada. He is on the staff of Harper Hospital.

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Marvin S. Finkelstein is associate professor of Sociology in the Department of Sociology and Social Work at Southern Illinois University

at Edwardsville. He has developed an undergraduate applied sociology program in Employment Relations. He is an Ex Officio Member of the Southwest Illinois Labor-Management Committee. He has authored articles on the role of sociology in the field of workplace and industrial change which have appeared in the Journal of Applied Sociology, Sociological Practice Review and Teaching Sociology. His activities are currently focused on sociological practice in the global economy.

Jonathan Freedman is director of Education and Training at the Hutchings Psychiatric Center. He is a past president of the Sociological Practice Association.

John E. Glass is a doctoral student in sociology at the University of North Texas. His areas of interest are social psychology, clinical sociology, and socialization. Currently he is working at the Greater Dallas Council on Alcohol and Drug Abuse and at Texas Wesleyan University as an adjunct faculty member.

Edward W. Gondolf is a sociology professor at Indiana University of Pennsylvania (IUP). He also serves as research director of the Mid-Atlantic Addiction Training Institute (MAATI), a research faculty at Western Psychiatric Institute of the University of Pittsburgh Medical School, and program consultant to the Domestic Relations Clinic of the Pittsburgh V.A. Medical Center. His recent works on domestic violence include Battered Women as Survivors (1988) and Psychiatric Response to Family Violence (1990).

J. Barry Gurdin first covered the topic of the sociology of drugs when teaching criminology and deviance. Dr. Gurdin began to take a serious interest in chemical dependency when he had the opportunity to attend the lectures and participate in the methodological consultations of the late Professor Louis Guttman at The University of Chicago Parent Health and Infant Development Project which studies methadone-maintained women and their infants. Professor Joseph Marcus, now retired, was the principal investigator of that research team. Dr. Gurdin has been a visiting scholar and/or research associate in the Departments of Sociology and Anthropology at the University of California, Berkeley. Besides counseling chemically-dependent people, he has had a contract to do the quantitative data analysis of a project studying people getting off methadone in the Bay Area.

David May obtained a B.A. in History from the University of Bristol in 1962 and a Ph.D. in Sociology from the University ofAberdeen in 1975. Following 10 years at the Medical Research Council's Medical Sociology Research Unit at Aberdeen and a spell teaching in the United States, he moved to Dundee where is Senior Lecturer in Sociology in the Department

of Psychiatry at the University of Dundee responsible for the teaching of Sociology to medical students. He has researched and published extensively in the areas of juvenile justice and mental retardation.

Michael Kelly was born in London and educated at the Universities of York, Leicester and Dundee. He is presently senior lecturer in the Department of Public Health at the University of Glasgow. His main interests are in the sociology of chronic illness and surgery. He has published extensively in the fields of chronic illness, rehabilitation, patient education and health promotion.

Phillip D. Robinette is an associate professor of sociology and Chair of the Division of Social Sciences at Southern California College. He has just completed a two-year term as president of the Sociological Practice Association while he simulataneously served as the Coordinator of the Coalition for the Utilization of Sociology. He is Certified Clinical Sociologist and directs the Life Enrichment Center which offers individual and group sociotherapy, organizational consulting, and seminars/retreats for various types of groups. Research interests and seminar topics include marriage enrichment, parent-child/teen relationships, conflict resolution, decision-making, clergy spouses, stress management, and the impact of social change on individuals and groups.

Prof. Joao Gabriel Lima Cruz Teixeira is currently associate professor and Head of the Department of Sociology at the University of Brasilia. He received his M.A. in Sociology fromt he University of Miami in 1970 and his Ph.D. in Sociology from the University of Sussex, England in 1984. He is the former Director of the Brazilian Sociological Association (1987-89.) His most recent book is Freud's Theory of Society, published in Sao Paulo in 1991.

Nancy M. Shields, is assistant dean of the Evening College and assistant professor in the Department of Sociology at the University of Missouri-St. Louis. She was the Principal Investigator on two research grants on family violence from the National Institute of Mental Health and is the co-author of nine book chapters and journal articles on marital rape and battering. Currently, she has received a research grant from the National Academic Advising Association to study factors influencing the success of nontraditional students.

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Randy Stoecker is an assistant professor at the University of Toledo. He has published in the areas of social movements and social theory. He continues to be involved in the Working Group on Neighborhoods in Toledo. His latest participatory action research project studies the relationship between community organizing and community development.

David Beckwith is a research associate in Neighborhood Development at the University of Toledo's Urban Affairs Center and a Field Consultant for the Washington, D.C. based Center for Community Change. The Internaitonal Downtown Association recently printed his article on "How to Run a Good Meeting."

Diana J. Torrez is an assistant professor at the University of North Texas. She researches and teaches in the areas of health, aging and race relations. She received her bachelors' degree (1983) and her Ph.D. (1990) from the University of New Mexico. This article is the result of research which was conducted for her dissertation, "Sudden Infant Death Syndrome (SIDS) in New Mexico." This research examined both the epidemiology of SIDS and the grief process associated with Sudden Infant Death Syndrome. Dr. Torrez continues her research in the health area and is presently researching the effect of socioeconomic status on Mexican-American birth outcome.

Mary Sengstock is professor and former chair of the Department of Sociology at Wayne State University in Detroit, Michigan. She holds a Ph.D. in Sociology from Washington University in St. Louis, Missouri. She is also a Certified Clinical Sociologist. Dr. Sengstock's areas of specialization include several areas with a strong clinical aspect, including applied sociology, family violence, and gerontology. She not only teaches courses in these areas, but also conducts in-service training for professionals working with clients in these areas.

History of Clinical Sociology

Jan Fritz
California State University-San Bernardino

For about twenty years, starting in the mid-1920s, sociologists directed or were centrally involved in clinics in Chicago, Nashville, New Orleans, Columbus, and New York City. One of these sociologists, Harvey Zorbaugh, directed the Clinic for the Social Adjustment of Gifted connected with the School of Education at New York University.

Zorbaugh discusses his work in his 1939 article "Sociology in the Clinic." The article appeared in *The Journal of Educational Sociology*, a monthly (September through May) school publication. Zorbaugh was an associate editor and book review editor for the journal. The issue in which Zorbaugh's article appears is entitled "Contribution of Sociology to Education" and focuses on the educational sociology program at New York University.

SOCIOLOGY IN THE CLINIC

Harvey Zorbaugh

The past twenty-five years have witnessed a great change in the behavior of sociologists. A quarter of a century ago the majority of sociologists may fairly have been called philosophers or reformers. They dreamed on the one hand of cosmic cycles in the affairs of men; on the other hand, of utopia realized on earth. Today the great majority of sociologists—at least of the younger generation of sociologist—are scientists, attempting to develop methodology and techniques which will yield a greater understanding of, and, we may hope, control over a man's social behavior.

Many factors inherent in the cultural trends of our generation have contributed to this change. It has not been the result of sociological thought alone, much less the achievement of a particular "school" of sociology. On the other hand, it was at the University of Chicago, in the graduate department of sociology, in the decade following the war, that the sociologist's changed conception of his role was first clarified and began to yield fruit in the type of research now characteristic of sociological science.

The sociology department of the University of Chicago was an exciting intellectual atmosphere to the graduate students of that decade. The older concept of sociology was represented in the person of Albion Small, head of the department, then in the last years of his notable career. The emerging concept of sociology as science was represented by Robert E. Park and Ernest W. Burgess. In his first year the student came under the influence of both points of view.

Small was a scholar, in the finest sense of the word. He took the student through the history of sociological thought, requiring that the student document his progress as he went. Small was a logician as well. He insisted that the student should, if he could, reason his way through the documentary evidence. Small, the logician, strove to force the student to clarify and sharpen his conceptual tools, giving the student a rigorous exercise in semantics. Small was, furthermore, a philosopher, and strove to stimulate his students, through their study of the history of society, to achieve a valid philosophy and valid values of their own.

Park and Burgess, on the other hand, demanded that the student apply his developing sociological concepts to an analysis of the behavior of the community about him. Park, impatient with the older sociological theory, was on fire with belief that sociology could become, was becoming, a natural science. Park had a tremendously original mind, a rate ability to stimulate the minds of his students, and to transmit to them his enthusiasm. Park was, moreover, intellectually the most

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dents put them to work. All of his students would admit that credit for whatever contributions they have made to sociology must be shared with Park.

Park's mind, on the other hand, was largely intuitive. Science was, to him, a burning ideal and a way of thought rather than a methodology. It was Burgess who kept the student face to face with the necessity of working out an adequate and valid methodology for attacking his problems. It was to Burgess students turned over and over for methodological criticism and help. It was due to Burgess's originality and generosity that many of their projects bore fruit. Every student who has gone out of the University of Chicago to make a place for himself in sociological research owes much to Burgess for the discipline necessary to make research fruitful.

Students reacted differently to this intellectual atmosphere, according to their differences in temperament and experience. Many and heated were the debates that went on, among graduate students, in seminars, over the tables of the university commons, in smoke-filled dormitory rooms. There were those who felt that there could be no such thing as a science of sociology, that the sociologist should be content to try to give meaning to the history of society. There were others who conceded that a scientific approach to society was possible, but felt empirical studies incapable of control, could contribute little to such a science, and that its tools could be only those of logical process. The majority, however, fired with Park's and Burgess's enthusiasm, believed that a science of sociology must grow out of empirical studies of the social behavior of the community, and that methodology and techniques for such studies could be developed.

The establishment, in 1922, of the Community Research Fund, under a grant from the Laura Spelman Rockefeller Memorial, made possible the first comprehensive program of sociological research into the behavior of the community. This research has yielded, and continues to yield, data and generalizations that amply justify Park's and Burgess's belief in a scientific sociology.[1] It would seem fair to say that Park and Burgess, during this decade at the University of Chicago, played a role in the development of modern sociology comparable to that played earlier by G. Stanley Hall, at Clark University, in the development of modern psychology. As one attempts to evaluate the data and generalizations contributed to scientific sociology by their students, in the light of the trends of our contemporary society, one regrets, however, that these students do not reflect in their research more of the respect for the mind itself as a tool for arriving at truth, more of the recognition of the necessity of a valid philosophy through which truth may become socially fruitful, that Albion Small strove to give them.[2]

It was natural, and inevitable, that as sociologists turned from the study of documents to the study of collective behavior of men, many sociologists should become particularly interested in the social aspects of the individual's behav-

ior—the attitudes through which individual and group become part of a pattern, the effect of group relationship upon the individual's behavior, the mechanisms of interaction involved. This interest has loomed large in the research of the Chicago "school." It has led to much research on the borderland between sociology and psychology. If one chooses to call this field of research social psychology, it is evident that sociology has made significant contributions to a scientific social psychology.

This contribution has by no means been confined to the work of the Chicago "school." All over the country, younger sociologists, through varying backgrounds of experience, were fired with the belief that the scientific method is applicable to the study of social behavior, were carrying their research into the community, were, many of them, focusing their interest increasingly upon the relationship of group and individual. No more significant contribution has been made in this area of research—to mention but one example—than the Lynds' *Middletown* and *Middletown in Transition.*

Many sociologists interested in this field felt the need for access to clinical situations, in which their concepts and hypotheses as to the relation of the group and the individual might be tested, modified, validated. Moreover, many sociologists felt that sociology had significant contributions to make in the readjustment of the individual to social living.

Sociologists found, however, that the psychiatrist, social worker, and psychologist had staked out the clinical field as their own, and gave scant welcome to the sociologist, scant consideration to his ideas. Sociologists were perhaps largely to blame for this situation. In their newly acquired worship of objectivity they were intolerant of many of the values and procedures of the clinic and social agency. Indeed, may younger sociologists developed, with reference to the psychiatrist, psychologist, and social worker, a conflict group psychology which was a denial of the objectivity they proclaimed.

The result was that sociologists began to talk of "sociological" clinics. A "sociological" clinic was to be a clinic which the sociologist controlled, or which a particularly brash young sociologist might undertake on his own. Clifford Shaw and the writer organized two such "sociological" clinics in Chicago in 1924—the Lower North and South Side Child Guidance Clinics, since affiliated with the Institute for Juvenile Research. May it be said, Shaw and the writer were not brash enough to undertake to be clinics by themselves. Psychiatrists, Psychologists, and social workers completed the staff. But these clinics were to be directed by sociologists, to serve as laboratories for validating sociological hypotheses as to individual adjustment and behavior.

In 1926 the writer was offered the opportunity of becoming a member of the faculty of the School of Education of New York University, where the department of educational sociology was projecting the establishment of a "sociolog-

ical" clinic. The writer came to New York, eager to grasp the opportunity—sure that a clinic, sociologically oriented and directed, emphasizing research, would contribute much to the educational work of the sociology department—through testing hypotheses, developing teaching materials, affording field experience for students.

The writer vividly remembers a conversation, shortly before the clinic began its work, in which Walter Pettit of New York School of Social Work participated. After considerable discussion and debate, Walter Pettit remarked, "You still have a lot to learn." The writer had a lot to learn. Some of the things ten years' experience with this clinic have taught him as to the role of a clinic in the work of a department of sociology are worth mentioning here.

In the first place, one cannot work long in a clinical situation before one is forced to accept the fact that a clinic's first responsibility is service to its clients. Research must wait upon service. This means that, unless the clinic has a very large case load, the materials through which given hypotheses may be tested are slow in accumulating. Moreover, cases that seem to offer opportunities for critical experiments often cannot be so utilized if the clinician accepts his responsibility to the client. As a result, the clinical situation bears the fruit of research but slowly. To those impatient for immediate results, the clinic proves to be a disappointing laboratory.

On the other hand, out of clinical work there are constantly arising problems that give rise to hypotheses for legitimate sociological research. For example, the finding in our own clinic that problems revolving about conflicts over the child's eating are referred predominantly from Jewish families. Whatever psychiatric mechanisms determine the way the Jewish mother may use the food patterns of her culture, there is obviously a sociological factor involved that is not only of theoretical significance, but of practical importance in approaching and dealing with such problems.

Many other illustrations might be given. Moreover, the ramifications of many of these problems may be formulated for research by able graduate students. Considerable such research has already grown out of clinically derived hypotheses as to factors involved in children's adjustment to the school.[3]

It would seem hardly necessary to warn sociologists interested in clinical research that a wholly "sociological" clinic is a fruitless undertaking. Without the meeting of minds trained not only in sociology, but as well in medicine, psychiatry, psychology, and case work, too many factors are unrecognized or unanalyzed to make case records of research value.

Such a meeting of minds is increasingly possible as sociology, psychiatry, case work, and medicine draw more closely together in understanding. The work of the Institute for Juvenile Research, the Hanover Conferences, the Coloquia on Personality of joint committees of the American Psychiatric

Association and the American Sociological Society, the Institute of Human Relations at Yale are significant symptoms of this meeting of minds. The recent publication by Plant, a psychiatrist, of *Personality and the Cultural Pattern*, and by Faris and Dunham, sociologists, of *Mental Disorders in Urban Areas* vividly illustrate the promise of this meeting of minds, through achieving a more fundamental understanding of human behavior, to increase and validate the hypotheses of all the behavior sciences concerned, including those of sociology.

There is no question that clinical experience greatly enriches the sociologist's teaching material. In this respect, the department of educational sociology clinic has paid tremendous dividends, greatly increasing the validity and vitality of the teaching of those who have participated in its work. The case records of every sociologically oriented clinic are a mine of living material on the role of social and cultural factors in shaping the individual personality and in conditioning its adjustment, on the role of the sociological factors in the family, gang, school, and community, on the processes that give rise to the many types of antisocial behavior, on the effect of various patterns of group life upon members of the group. Such material aids greatly the teacher's attempt to lead the student to apply his theoretical concepts to the analysis of the social behavior of the community.

The writer believes, then, as a result of his experience, that the clinic has much to contribute to sociological theory. The clinic, further, serves greatly to enrich the work of a department of sociology. To achieve these results a clinic need not, however, be the proprietary interest of a sociology department itself. As the behavior sciences draw closer together, sociology departments will increasingly find their clinical needs met by participation in general university clinics, and in the work of clinics and other social agencies in the community.

1. Nels Anderson, *The Hobo*; Frederic M. Thrasher, *The Gang*; Louis Wirth, *The Ghetto*; Ernest Mower, *Family Disorganization*, and his subsequent studies of the family; Harvey Zorbaugh, *The Gold Coast and the Slum*; Clifford Shaw, Frederick Zorbaugh, Henry McKay, and Leonard Cottrell, *Delinquency Areas*, and Shaw's subsequent studies from the Behavior Research Fund and the Institute of Juvenile Research; Hiller, *The Strike*; Walter Reckless, *The Natural History of Vice*; Ruth S. Cavan, *Suicide*; Herbert Blumer, *Movies and Conduct*; Robert Faris and H. Warren Dunham, *Mental Disorders in Urban Areas*; to name only a few of these studies.

2. Louis Wirth is a notable exception, in the writer's opinion, to this statement.

3. Julius Yourman, "Children Identified by Their Teachers as Problems," *The Journal of Educational Sociology*, February 1932, pp. 334-343; Louise Snyder, "The Problem Child in the Jersey City Elementary Schools," *ibid.*, February 1934, pp. 343-352; Mildred Fisher, "Measured Differences Between Problem and Nonproblem Children in a Public-School System," *ibid.*, February 1934, pp. 353-362.

Sociological Practice's Mid-life Crisis*

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ABSTRACT

Variables borrowed from the literature analyzing the middle years of American adults are used to pose questions and suggest answers regarding the mid-life organizational stage of development of sociological practice (applied and clinical) as a professional subspecialization within the discipline Comparisons are made. Issues are raised which require a response and a resolution if sociological practice is both to survive and surpass the potential pitfalls of its organizational mid-life crisis.

Introduction

In my private sociological practice of nearly two decades, I have encountered several clients who were coping with problems centered on mid-life issues. On the organizational level was a religious denomination of local churches, which, as it moved upward on the church-sect continuum, struggled to retain the sense of mission which brought it into existence in the first place. Another case was that of an affiliation of private colleges trying to maintain their unique organizational identities while experiencing differential survival rates within a competitive and ever-changing environment.

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On the group level were several marital dyads grappling with what to do after the partners had fallen out of love. In another case, a subgroup within a voluntary organization was told to increase its membership and productivity or face extinction. Examples from the individual members of the group level include angry spouses of clergy members, who attempted to blackmail their partners into abusing their professional roles, and an upwardly mobile educator who labored hard for years to attain the highest possible social position, only to quit and take a job not requiring even a graduate education.

Examples of organizations experiencing mid-life difficulties occasionally appear in the popular press. PC WEEK, the National Newspaper of Corporate Computing, in its 6 May 1991 issue featured a headline article entitled, "Once-Invincible Compaq Beset by Midlife Crisis." It reported:

> Compaq Computer Corporation has lost its midas touch. The nine-year-old Houston company, in a midlife crisis, is being squeezed by cloners swarming over its traditional market and by workstation vendors moving onto its turf. Wall Street is not happy. Compaq is looking at its first down year in company history. Stock brokers recommend that shareholders sell their stock. Can Compaq prove the skeptics wrong? It may be months before a new strategy pays off.

The mid-life period is often marked by reappraisal of personal and organizational missions. Notably, this is the rationale given by Rebach and Bruhn (1991) in their preface to the new Handbook on Clinical Sociology:

> This book is an outgrowth of the reemergence of clinical sociology as a formally organized subdiscipline. In the late 1970's, a group of sociologists met and formed the Clinical Sociology Association. This organization was formed outside the mainstream of sociology, largely because these individuals were actively engaged in intervention and social change but did not find mainstream sociology supportive of their efforts. However, these individuals felt the need to establish a community of interest and share information. They also felt that, by organizing, they could increase awareness of sociological practice and be a catalyst for further developing the discipline. . . . We feel that, after a decade, it is appropriate to assess our present status and suggest directions for its further development and encourage sociologists and allied disciplines to join in the

> progress of clinical sociology and sociological practice. Therefore, we submit this book.

Albert Gollin (1983), also commented on the mid-life-like status of applied sociology:

> The workshop on applied sociology that led to this book is only the most recent of a series of attempts to confront the persistent tensions—between knowledge and action, between theory and practice, and, more generally, between academic and applied aspects of the discipline—that have characterized American sociologists since its inception. The inclusion of 'practical sociologists' as members was a question debated—and answered affirmatively—at the 1905 organizational meeting of the American Sociological Society. . . . But the legitimacy of applied sociology and its practitioners has remained a contested issue.

Howard Aldrich's (1979) definition of an organization seems to fit particularly well as a conceptual basis for examining the Sociological Practice Association's reaction to its mid-life crisis. He posits that organizations are goal-oriented, boundary-maintaining, activity systems. It is within these domains that all organizations must maintain diligence to continue to viably exist.

Descriptions of Mid-life

Developmental Transition

The mid-life period represents a "turning point or boundary region between two periods of greater stability" (Levinson, Darrow, Klein, Levinson, & McKee, 1979, pp. 288, 289). This conceptualization is fundamentally encouraging because it suggests that a temporary lull in developmental progress is only a prerequisite to further accomplishments. The lesson here is to avoid the temptation for pessimism or fatalism while traveling in the valley between a rich past and a promising future.

Identity (Self/Social)

Niederhoffer (1967, pp. 18,19) suggests criteria that define a profession. These could be used to aid in the ongoing decision-making process as an orga-

nization through the arduous procedure of identity adaptation. The elements of professionalism are:

(1) High standards of admission
(2) Special body of knowledge and theory
(3) Code of Ethics
(4) Altruism and dedication to a service ideal
(5) Lengthy training period for candidates
(6) Licensing (certifying) of members
(7) Autonomous control
(8) Pride of the members in their profession
(9) Publicly recognized status and prestige

Risk (Change)

At last year's (1990) annual meeting in Providence, RI, Bob Harris and I (Robinette & Harris, 1990) conducted a workshop on computerized decision-making models at which one of our attending colleagues agreed to serve as the illustratory "guinea-pig" for the true-to-life test of the model's interventionary capabilities. The problem presented was a critical decision centering on whether or not to risk leaving a tenured academic position to engage in an unpredictable private practice. This is apparently a common dilemma among persons attempting the transition into sociological practice positions.

Alfred Lee (1984) identifies two trends providing expanding opportunities within the sociological practice sector. They are the proliferation of specialties within sociology and the fragmentation of sociological organizations. Although these factors may open new doors for individual sociologists, they may also add to the developmental stress of sociological organizations undergoing organizational metamorphoses brought on by mid-life crises.

Powell and Driscoll (1979) shed some light into the emotional cost to professionals when such transitions from bureaucratic continuity to a professional sociological practice end in failure. They identify four stages of personal response in their study of middle-class professionals facing unemployment:

Stage 1: Period of relaxation and relief
Stage 2: Period of concerted effort
Stage 3: Period of vacillation and doubt
Stage 4: Period of malaise and cynicism

Cost/Benefit Analysis of Previous Choices/Decisions

Persons/organizations going through a mid-life period often begin to second-guess previous decisions. Instead of confidently building on the foundations of

previous decisions, people/organizations facing such a crisis are often plagued with doubts about the wisdom and viability of past decisions, resulting in a temporary state of progressional paralysis.

A frequent concomitant of this reassessment process is an attempt to determine the closeness-of-fit of the self with the various social structures with which it is associated. Questions like, "Do I like who I have become?" and "Am I happy with my current repertoire of roles?" are frequently raised. These same questions may be posed by organizational leaders regarding the structure and functions of their professional associations.

John Glass (1985, p. 81) reinforces this point when stating that work (in this case professional practice or organizational activity) is the "proving ground against which we define and value ourselves as adults." This is not an automatic process to be taken for granted. As Glassner and Freedman (1979, p. 345) observe:

> Organizations are compromises. They meet no individual's needs fully. Even the person at the top usually feels frustration. Organizations can be efficient, but usually cannot maintain a high level of efficiency over a long period. Organizations can be quite understanding of the human condition, but usually they fall far short of reflecting human concerns.

Bodily Decline

One issue frequently associated with mid-life crises is bodily decline. This may be in the form of personal/organizational health, stamina, energy, or appearance, and may be either perceived or actual. Organizationally, it may be measured along a continuum ranging from vitality to stagnation. It may be an issue of virility (attractiveness, competitiveness, and marketability). When these aspects are viewed as deteriorating this view becomes a symptom of mid-life crisis.

Sense of Mortality

Sooner or later it dawns on people/organizations that the wave of growth and progress they are experiencing will not continue indefinitely. As we watch the circulation of individuals occupying organizational roles, we may erroneously conclude that organizational members change but that the organizations themselves live on forever. However, as growth and progress begin to slow, the stark reality of the possibility of organizational death becomes an increasingly

dominant idea and possibility. It can even lead some into the panic reaction of prematurely attempting to abandon a sinking ship that may not, in fact, even be in serious jeopardy.

Organizational members may suffer from a version of the "empty nest syndrome" as they are continuously required to adjust to modifications in organizational configurations. These modifications involve a wide range of interpersonal relationships within the organizations all the way from the loss of friendships to alterations in power relationships and the tenuousness of prestige level maintenance. Saying goodbye to proteges and professional colleagues is often difficult. However, the prospect of facing the cessation/extinction of a longtime association with a professional organization is, to many, a frightening and insurmountable prospect.

Causes of Mid-life Crises

Goal-Gap

Goal attainment is a prerequisite to organizational perpetuity. A sociological practice organization's goals may be to attract into membership the majority of the practice community; to have a surplus supply of volunteer leader candidates; to significantly influence the character and direction of its academic and professional root discipline; to receive maximum acceptance for the scholarship of its publications; to attain a large market niche for its practicing membership; and to achieve widespread public acknowledgement of its societal contribution. When such goals are not achieved, organizational disappointment, discontent, and internal crises can emerge.

At least part of this gap between an organization's goals and actual achievements can be explained by the tension existing between professional and bureaucratic forms of organizational structures. Along the axis of loyalty, bureaucrats tend towards selling their soul to the company store, whereas professionals tend to identify first with their professional fellows. Professionals then are most often occupants of staff rather than management. This is an asset for issues of autonomy and objectivity but often a liability in terms of positional authority and direct influence on consequential decision-making.

Rubin (1983, p. 35) discusses organizational constraints which hamper applied social research. He points out:

> In bringing research data to the decision maker, the applied social researcher is bringing truth to power. This is somewhat of an iffy process:

1. Power might have ideological reasons for opposing truth.
2. Truth might adversely affect the organization.
3. Decision makers may have other sources of truth.
4. Truth might be unacceptable for narrow political reasons.

The issue of whether to allow the tempting lure of profession peer pressure to put personal success over and above a professional code of ethics is raised once again in the Chronicle of Higher Education (Raymond, 1991, pp. A4-A6), The article reveals that a study of patient histories suggests that Freud suppressed or distorted facts that contradicted his theories. Cheating does not reduce nor eliminate the gap between goals and attainment. It only serves to contribute to the crisis!

Burnout

People/organizations can grow weary of well-doing. This is expecially the case for practicing sociologists, who, from a social exchange perspective, often give much more than they receive. This imbalance occurs for a variety of reasons:

1. Sociology's relative small size in comparison to other disciplines practicing within the helping professions.
2. Sociology's lack of follow through in developing its applied and grounded practice specialties at the expense of more abstract empirical investigation and theory-building.
3. Sociology's inability to be competitive in acquiring recognition by state licensing/certification boards.
4. The lack of career opportunities for sociologists in the U. S. Bureau of Labor's Dictionary of Occupational Titles.
5. Sociology's lack of public relations prowess in informing the public at large about the potential significance of its discipline to the everyday life.
6. Sociology's liberality in allowing previously held academic/professional territories to be taken over by other disciplines.
7. Sociology's refusal to expose its strongest members in lower division or undergraduate courses where the greatest potential for new member recruitment exists.
8. Sociology's ineptness at creating clear career paths for bachelor's level graduates.
9. Sociology's inability to utilize its own social skills to expand its sphere of influence and jurisdictional domain even within those organizational structures in which it already co-exists with competing disciplines and interest groups.
10. And perhaps most distressing of all, sociology's apparent willful withholding of accumulated data and knowledge of social life from the occupants of the very social structures from which it was collected!

All of these weaknesses within sociology contribute to professional and organizational burnout, which in turn is a contributing factor mid-life crises. Such circumstances as these can lead to demoralization, discouragement, and disengagement from a worthy professional pursuit. Or, as Sheehy (1979, p. 295) aptly phrases it, "seeing the dark at the end of the tunnel."

Responses to Mid-life Transition

Stability and Continuity

For many people/organizations, mid-life is a period of increasing relaxation. If past activities have resulted in strategic positioning and constructive growth, this can be a developmental sequence characterized by:

1. Growing income (expansion of client/membership base)
2. Increased leisure (higher level positions with more discretionary time)
3. Fewer child-rearing responsibilities (work with seasoned professionals rather than neophytes)
4. New opportunities available (high point of professional reputation and desirability)
5. Expanding family structure (networking contact list at an all-time high)

Manageable Transition

For many, going through mid-life is a beatable challenge. Vaillant (1977) identifies some of the factors which make the transition manageable in his longitudinal study of two hundred Harvard graduates of 1942-44. Factors contributing to better adjustment in that sample are:

1. Higher incomes
2. Steady promotions
3. Regular pastimes or athletic activities with friends
4. Use of allotted vacation time
5. Enjoyment of work role
6. Absence of drug/alcohol misuse
7. Fewer than 5 days of sick leave per year
8. Marital enjoyment (stable/happy marriages for at least 15 years)

Crisis

For others, the mid-life period is one of increasing stress. Stressors arrive from so many directions simultaneously that the very survival of existent social

structures and their capacity for adaptable resiliency is tested almost beyond the limits. The following stressors are primarily descriptive of characteristics associated with an individual person's adjustments to physiological and social changes linked to going through the life cycle. They are secondarily applied here to similar changes that take place in the lives of professionals and professional organizations.

1. Menopause. The actual or perceived loss of the ability to generate creative solutions to problems. There is an increasing reliance on previously discovered research findings and sociotherapeutic techniques. The well or mine of innovative professional resources seems to be running dry. The accumulated past is given precedence over future discovery. A decreased sense of professional competitiveness is frequently a concomitant, as other colleagues and service organizations are continuing to be successful with creative responsiveness to changing needs.

2. Loss/assessment of the parenting role. Newer and younger organizations often experience the phenomenon of the frequent infusion of new persons into the group. This contributes to a dynamic environment where resources for leadership and tasks seem almost unlimited. Almost any idea can attract interest and people willing to transform it into a social reality. The constant readjustment to new faces and to the changing personality of the organization produce excitement, the sensation of making progress, and substantial output that is recognizable in the larger professional context. During mid-life, organizational membership may stagnate or even decline. A diminishing group of diehard leaders feels stuck with doing more and more of the day-to-day tasks necessary to keep the organization afloat. Their former role of developing younger professionals to take on proudly the responsibilities of organizational perpetuity becomes a mere memory. Hard to answer questions resonate in analytical minds. "Why aren't there more enthusiastic candidates for organizational mentoring? Does our offspring's lack of continuing interest in the organizations that helped to launch them into their careers indicate some kind of failure on their parent's part? If we could redo the past, would we do things differently?" Why even ask? We can't.

3. Pressure to attain work goals. Mid-life represents the realization that life is finite. There is not an unlimited amount of future time in which to make significant contributions to a profession or clientele. Objectives will not be reached on their own initiative or momentum. Is even professional desire, planning, and activity enough to guarantee attainment? Obstructions seem to outnumber avenues. Competitiveness outpaces cooperation. Cynically, many professional networks and organizational affiliations are entered into for personal gain, rather than mutual sharing for obtaining superordinate goals. If

goals are ever to be attained, it must be soon. Time is running out. Windows of opportunity are closing.

4. Personal reassessment. Are we satisfied with how our organization has turned out? How do we feel about the roles we play in it? Have our efforts been worth it? Would we classify ourselves as successes or failures? How do others perceive us? How many distinguished service awards have we received from our fellows? How many clients have referred others to us? How influential have our individual and collective contributions been in shaping the present and future state of our discipline and applied/practicing sociology? Have we made a noticeable difference? Or, have our inputs been canceled out or outflanked by competitors? Should we continue trying or throw in the towel and let others carry on from here?

5. Diminished sexual capacity. The fear or actual experience of social impotency is demoralizing. Early signs may include a lack of responsiveness to previously stimulating aspects of professional/organizational life. Experiences in the past that aroused excitement and contemplated enjoyment have lost their appeal. Others around you seem to be enjoying themselves immensely while you feel no enjoyment. You may find yourself going through the motions of fulfilling professional roles without experiencing the positive emotional or social payoffs of the past. The temptation to withdraw socially and let the rest of the professional community go on living more meaningful lives becomes a candidate of choice. Reluctance to engage in new relationships or coalitions may emerge due to the belief in your inability to contribute meaning and pleasure to new partners. Such attitudes and behavior or lack thereof may result in relational disconnectedness and isolation.

6. Physical changes. We cannot escape the impact of bodily factors and changes. Our bodies accompany us everywhere we go and serve to accelerate or constrain our activities. Likewise, the structure of our resume/vitas and practice organizations may either serve to propel us on to even greater possibilities or serve as a ball and chain around our ankles dragging us to a near standstill. Mid-life is a time when our structure begins to intrude on our functionability. We may begin to disdain its appearance and encumbrances. The structure may become socially embarrassing. If we can't satisfactorily modify it, then we may be forced to accept it in order to continue forward progress.

7. Caring for aged parents. What do we do with former practice superstars who no longer seem capable of making outstanding contributions? Can their previously brilliant, though presently outdated and superseded, offerings endlessly propel them into the limelight of their professional peers? Do we discard them into obscurity or do we continue to respect and honor them on the merit of their previous work? Fortunately, it is our custom to build all current arguments on the foundations of the past. Citing previous works is our standard

operating procedure. The consequence is that during our own middle age we must assume the additional responsibility of making provision for the needs of the mentors and role-models who helped to launch our own careers. Generally, this is a task which is welcomed by both individuals and organizations. It is part of the reality of the life-cycle process, and we all realize that our own turns as the cared-for will eventually come.

8. Sexual promiscuity. Just how strong is our commitment to sociological practice? Mid-life is a time when many begin to flirt with alternative professional disciplines. Wherein does our real loyalty lie? Does it reside in sociology, what is best for our own careers, our clients, public opinion, or some nebulous wandering through a series of open and closed doors of opportunity? It is at this point that many ask whether previous decisions have been reactions to the proposals and expectations of others or a result of personal proaction. The rational course may be to proceed in the direction cast by previous decisions. However, mid-life for many is a period of illogical confusion and unexplainable experimentation. Sociological practice, because of its relative newness as an entrant in the ring of therapeutic interventions, is often treated as the new kid on the block whose contribution is viewed as suspect by the more established and prestigious occupants of power positions and third party insurance vendors. Lack of professional recognition, nonqualification for certain licenses to practice, lower fees for similar services, and exclusion from direct insurance reimbursement can discourage even the most determined and hardy among us. After five years of arduous academic work beyond my bachelor's and master's degrees to earn my doctorate in sociology for having demonstrated competence to do original research, I encountered several three year non-academic professional programs in psychology which would have met the requirements for licensure in the state of California as a clinical psychologist! A person's belief and trust in the viability of sociology's particular contribution to the resolution of human interactional dilemmas can be sorely tested.

9. Negative emotions. Emotions are often involuntary. However, they are frequently caused by identifiable psycho-social stressors. The cumulative effect of the previously mentioned contributors to crises can cause sociologists to experience emotional responses of a magnitude that render routine coping mechanisms insufficient. Unrelenting bouts of depression, frustration, anger, rebellion, anxiety, and guilt may result in introspection and self/social doubt. Minimally, these negative emotions serve to distract the sociologist from concentrating on professional issues. A frequent consequence is a noticeable reduction in practice productivity. This may result in negative feedback, adding additional insult to injury. The worst possible response is reduction of hours devoted to practice and separation from cohorts. This only gives one more time to wrestle with internal mental foes, instead of engaging in constructive activ-

ity and peer support. Helping professionals and helping organizations are uniquely susceptible to burnout, especially during the mid-life time frame. When a person/association is buried under an avalanche of debilitating emotions, help must come from outside the self. This is the essence of sociology: assistance which originates from outside environmental sources. Clearly, we need each other to conquer such crises.

10. Self-destructive acts. The ultimate sign of impending crisis occurs when sociologists and their organizations engage in the very destructive behaviors which they have prepared themselves to overcome in their clients via intervention for constructive change. It is ironic that helpers and helping organizations are vulnerable to the same maladies as their patients. This fact is one of the great equalizers of life. No known social boundary (class, status, power) makes an entire category of people immune from life's exigencies. Shostak (1988) cites five of the major weaknesses of twentieth century sociologists:

a. The propensity of practitioners to go it alone.
b. The poor use made of data.
c. The failure to disseminate findings.
d. The lack of influence exerted in policy-making.
e. Bitter division over populists (clients) and elitists (organizational power brokers).

Resolving Mid-life Crises

1. Recognize and accept the changes that are taking place. Sadler (1990) makes a statement about rewriting middle-aged scripts:

> An increasing number of adults in mid-life show signs of growth rather than decline, denial, stagnation, or stoic resignation. What are the signs of growth? The Growers remain healthy and active. Their basic attitude is openness to reality and change rather than denial. . . . They are becoming more open, flexible, and inventive rather than mindlessly narrow, rigid, and repetitive. They seek new adventure rather than trying to hold on to what is well known.

2. Admit our dark side. Sheehy (1979) encourages us to go ahead and confess that we are selfish, greedy, competitive, fearful, dependent, jealous, and possessive. Discontinuing hypocritical denial is a significant first step to applying our own helping mechanisms to our shortcomings. Refusal to face reality only serves to postpone the arrival of escape routes.

3. Conduct a social systems analysis. Here is a solution with which we feel competent. Rader (1986, pp. 64-65) reminds us of our own peculiar perspective:

> Implicitly or explicitly the assumption is made that age-related crises are natural, healthy, and progressive and that they are generated internally irrespective of social- historical context. . . . As an alternative model, the major assumption of this paper is that age-related crises are largely socially constructed and that developmental psychology is an ideology that serves to legitimate overspecialized age roles and the suffering that ensues from ageism.

Britt (1988) analyzes organizational adaptability in response to environmental jolts. He examines three critical performance levels: one, at the time of the jolt; two, at the lowest point after fall off in performance; and, three, during recovery. He also investigates three time periods: one, resistance (how long it took for performance to fall off); two, resilience (the time it took to recover performance); and three, retention (how long recovery lasts before decay). We are the avowed experts at taking such analyses from the empirical on to the applied and practice domains. Let's do it.

4. Discuss our feelings with others. Herein lies an asset of sociability: going beyond the superficiality of networking and group participation primarily for social positioning. It is imperative to cultivate primary group characteristics within the milieu of our secondary group affiliations. Conversations need to go past "sociological business" into the arena of interpersonal and intraorganizational intimacy. We can then offer support to one another in times of mid-life related stress.

5. Move from the construction to the reconstruction of social reality (Berger & Luckmann, 1966). In my own practice I advocate weekly meetings for couples, families, and groups to participate actively in the gradual and ongoing reconstruction of their social realities (Robinette & Harris, 1989). It is important to note that this involves a process and not an event. Our status at any given point in time represents more of a location upon a continuum than a position in one of two dichotomous conditions. This is encouraging inasmuch as positive change constitutes a turning in direction along the continuum rather than some kind of quantum leap from an undesirable to a preferred condition. From such a perspective, even small movements can be interpreted as progress yielding a rationale for continuing optimism.

6. Riding out the down side (Sheehy, 1979). There is a recursive nature to human events. As the natural world illustrates (day/night, yearly seasons, flowers/seeds, animals shedding their skins, etc.) what on the surface may appear to

be dark, gloomy, and even mortifying is really part of a basic process of death and resurrection essential to the survival of life upon earth. Therefore, a redefinition of the situation is in order when the downside is being observed. The situation must be interpreted more holistically, keeping the entire cycle in consideration. One must remember that even the most devastating of storms does come to an end, after which the process of rebuilding can begin. Security within an environment of constant change requires adherence to the forces underlying these more universal regenerating processes.

7. Rites of passage. One way to conceptually simplify a complicated journey is to regard it as a normal sequence of experiences required to travel from one location to another in sociological space. If a map through the issues of mid-life could be somewhat uniformly accepted, then travelers could maintain a sense of where they are, have been, and are going. Lacoursiere (1980) suggests a series of stages that most groups go through as they develop. Sequentially they are: orientation, dissatisfaction, resolution, production, and termination. The heart of its application here is to concentrate on the three middle stages occurring between the formation and termination of social groups. What is portrayed echoes the tenets of the conflict perspective, a repetitive cycle of dissatisfaction and resolution followed by increased productivity. The goal here is not to get bogged down with the dissatisfaction stage. Focusing on the processes of resolution and production serves as a rite of passage through the potential quicksand of dwelling on and exaggerating the dissatisfaction stage. In my practice, I have found three helpful aids to this process: one, accepting the natural process of expansion and contraction; two, placing time limits on personal and organizational commitments; and three, praising and encouraging contributions rather than criticizing and discarding our fellow laborers.

Conclusion

We might learn something from religious organizations, which have a form of reductionism manifested in the ideology of generation, degeneration, and regeneration. McNiel and Thompson (1971) discuss at length the regeneration of social organizations. They introduce such terms as "demographic metabolism," which refer to a sustained yet dynamic social composition. They remind us that social organizations often exhibit continuity despite the coming and going of human components. Regeneration rate has to do with the change in the ratio of newcomers to veteran members of a social unit. These regeneration rates vary because they are a joint function of attrition and growth or shrinkage. For complex organizations, they conclude, growth will be greatest

under conditions of heavy recruitment and light attrition. Is this not the challenge to the continuing viability of sociological practice associations?

Gutknecht (1988) offers many helpful insights:

> We must learn to perceive human resource issues in more creative ways. . . . We need to invest in the maintenance of our human capital, just as we invest in the maintenance of physical capital. . . . We need to make a distinction between machines which break down more readily and people who are capable of refreshing and rejuvenating themselves. . . . Organizational Health Promotion results in increased productivity, improved performance, enhanced public image, employee protection, boosting morale, and in aiding recruitment.

John Bruhn (1991, p. 197) concurs and emphasizes that wellness and health promotion is a positive lifelong process. Johnson (1986), in using sociology to analyze human and organizational problems, reminds us that "theories can stimulate sociologists to assess whether their priorities focus on the maintenance of organizational structures or on the fulfillment of human needs!" Clausen (1990) discusses in detail the idea of conceptualizing stages of development along the life course as turning points which can lead to either stagnation or continued growth. It seems prudent to decide collectively that we want to move onward and upward in a manner conducive to both personal and organizational symbiotic growth.

In order for us to survive and surpass our own mid-life crisis, sociological practice (clinical and applied) needs our individual and collective energy and enthusiasm in our individual workplaces, professional affiliations, and public image.

The choice is up to us. Each of us. All of us.

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Integrating Psychodynamic, Cognitive, and Interpersonal Therapies: A Biopsychosocial Role Theory*

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ABSTRACT

A biopsychosocial role theory has been developed to integrate the main findings of psychodynamic, cognitive, and interpersonal therapies. To function in a society, you must achieve a balance between your self-expectations and your performances, and your expectations of others and their performances. These expectations of self and others fall roughly into 16 biopsychosocial areas, or life vectors Imbalance between expectations and performance creates stress. When experiencing stress, you must either modify and negotiate expectations and performances with others, or through defense mechanisms and patterns of reaction, further compound your problems. Interview schedules structured according to this theory have been used to interview patients, parents, and spouses. Social summaries allow the respondents to identify their problems and provide them with a common structure, methodology, and language to resolve their differences of opinion, restructure their roles, and achieve their personal and interpersonal goals.

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Continuity of treatment is a serious problem in the delivery of mental health services, and community mental health facilities have recently been criticized for their failure to provide medical care (Hilts, 1991). When hospitalized, patients are often treated by a multidisciplinary team, but the length of their hospitalization is short—an average of ten days. After discharge, patients are referred to private therapists, hospital outpatient departments, or community centers, depending on their insurance and financial resources. Thus, over a period of time, patients may be treated by therapists with different theoretical orientations. One therapist may focus on their medication, another on their childhood problems, a third on their present personal or interpersonal problems. After discharge, when a new problem occurs patients are often rehospitalized because they and their families are confused by this lack of continuity, and do not know what to do. They often believe that a recurrence of symptoms means that the patient will never get well, and they lack a model by which to evaluate the patient's progress.

This paper presents a theory of alternatives, a biopsychosocial theory of mental health which is based on role theory (Sarbin & Allen, 1968), and which combines the theories of these different theoretical orientations. We have explained in an earlier paper how the theory of alternatives was developed, tested, and operationalized (Ferguson, Ferguson, & Luby, 1991). Our main concern in this paper is to explain how the theory integrates some of the insights of psychodynamic, cognitive, and interpersonal therapies and provides a structure, methodology, and language which can help patients, parents, and spouses resolve their differences of opinion and achieve their personal and common goals.

Karasu (1990a; 1990b) attempted to integrate psychodynamics, cognitive, and interpersonal therapies and explain how these therapies could be used in the treatment of depression, but he did not provide us with a theory that integrates these three therapies.

Psychodynamic therapy is derived from Freudian theory. It focuses on helping patients to become conscious of the effects of past traumatic experiences on their present behavior. (Gabbard, 1990; Ursano, Sonnenberg, & Lazar, 1991). Under this therapy, patients become aware of the defense mechanisms they use "to avoid danger, anxiety, and unpleasantness" (Freud, 1937, p. 235).

Cognitive therapy is based on the underlying theoretical assumption that an individual's affect and behavior are largely determined by the way he interprets his experiences (Beck, 1976). Depression occurs because of maladaptive cognitive schemes. Manuals have been written to explain how cognitive therapy can be used for the treatment of depression (Beck, Rush, Shaw, & Emery, 1979; Burns, 1980), and even recently for the treatment of

schizophrenia (Perris, 1989), and personality disorders (Beck & Freeman, 1990). The techniques used include having patients monitor their own thoughts, identifying the patient's dysfunctional beliefs—such as overgeneralization, personalization, seeing everything in black and white—and cultivating beliefs that are more reality oriented.

Interpersonal therapy helps patients to acquire a sense of mastery, and a sense that they belong to the group instead of living in isolation (Sullivan, 1953; Klerman et al., 1984). The therapy focuses on the patients' assets, and helps them to ventilate painful emotions. Patients learn to solve interpersonal disputes, and deal with loss and role transitions.

Psychodynamic therapy is concerned with the patient's past traumatic experiences while cognitive and interpersonal therapies deal with the here-and-now. The boundaries between these three types of therapies may be artificial, however, because unless you understand the past, you cannot change the present, and to interact successfully with others you must continualy modify and negotiate your own expectations and performances.

A Biopsychosocial Role Theory

Two surveys led to the development of the theory of alternatives. The first study was an attempt to utilize Erikson's theory of the psychosocial development of children to test the repetitive pattern of maternal deprivation (Ferguson, 1962). Erikson (1956) proposed that a person had to go through a series of psychosocial crises to achieve a sense of identity, of knowing who he is and what he wants to do. Two of these psychosocial crises were: trust versus mistrust, and autonomy versus shame and guilt. The study on maternal deprivations showed, however, that children trusted others and acquired autonomy only if their self-expectations and their expectations of others were realized.

The second study was a survey of the adjustment of one hundred young widows (Ferguson, et al., 1981). We found that the widows' problems were biopsychosocial. Although experiencing severe emotional and physiological responses to their loss, they were nonetheless required to solve a wide range of financial, social, and ethical problems. These two studies led to the replacement of Erikson's concept of psychosocial crises by the concept of basic needs, or life vectors, derived from Malinowski's cultural imperatives (1960). Life vectors are defined as the basic biopsychosocial needs that are defined at the individual level and are sanctioned by the institutions of society.

Sense of Attainment

To function in a society you must achieve a sense of attainment which is reached through the knowledge that your self-expectations and your expectations of others are being met in all of your life vectors.

Self-expectations are defined as your expectations for your own actions, rights, and obligations. Expectations of others are defined as your expectations of others' rights and obligations. For example, you feel good because you are ready in time to see your therapist: you have fulfilled your self-expectations. But you are disappointed if your therapist does not appear: your expectations of others have not been met.

Complement of Life Vectors

Interaction with others is not confined to one life vector. As you grow, the demands society makes on you increase in size and scope, and you begin to interact with an increasing number of people. Life vectors are latent in a person, and the period in which they become manifest depends on maturation and the culture in which you live (Table 1).

Survival is a prime concern for the infant and the aged, so that health, nutrition, shelter, and motor development are all crucial to their welfare. Learning to communicate through speech and learning to walk is a concern of the toddler. Acquiring an education is a focus during childhood. In adolescence, social life, love and sex, the choice of an occupation, and finance become increasingly important. Parenthood is of concern to the young adult. A commitment to art, a respect for law and order, an interest in politics, religion, and ethics may develop in youth or become significant later in life.

Life vectors are not stages of development, but rather concurrent dimensions that can occur either simultaneously or sequentially. Life vectors can be conceptualized at different levels of generality. Under law and order, we can classify both how a child is punished by his parents and whether this child adheres to the laws of society. Life vectors are interdependent at a personal level: your financial situation may determine whether you can go back to school. But they are also interdependent at a national level, and must be considered when planning social change. For example, welfare mothers may decide to participate in occupational retraining only if they are assured that they will keep their Medicaid benefits while retraining.

Table 1. Complement of Life Vectors

Health	Occupation
Food	Finance
Shelter (housing)	Parenthood
Motor Development (exercise)	Law
Speech	Politics
Education	Art
Social Life	Religion
Love and Sex	Ethics

Role Theory and Interaction between Two Persons

The basic precepts of role theory are that attached to each of your statuses, or roles, are certain rights and obligations which are defined by you and by society (Sarbin & Allen, 1968). Role enactment occurs when you achieve your expectations, and role complementarity when you and another person agree on your mutual rights and obligations. The theory of alternatives is basically a role theory because it explains that you fulfill your basic needs by functioning in different roles and interacting with others. The human tragedy is that only performances are visible, and you can only infer expectations from performances.

Figure 1 represents the interaction between two persons, you (Ego), and another person (Alter) in one life vector. The circle in the middle of the diagram shows that only performances are visible. The long arrow from Alter to Ego shows that when Alter acts, he or she meets his or her obligations to you and recognizes your rights, and the long arrow from Ego to Alter shows that when you act you recognize Alter's rights.

When there is role complementarity between Ego and Alter there is no problem because you both agree on your mutual rights and obligations. When this is not the case you may experience anger if you believe that Alter did not recognize your rights; you may experience guilt if you believe you have not met your obligations; or you may experience both guilt and anger if you do not know who is to blame.

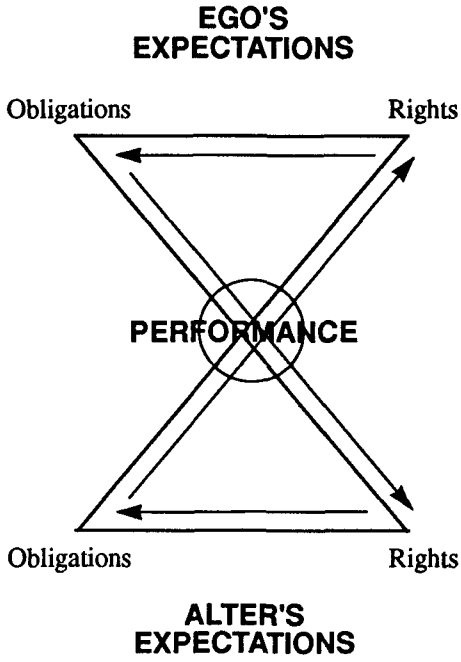

Figure 1. Interaction in Life Vector

Unmet Expectations and Stress

We propose that when you experience an imbalance between expectations and performances, you experience emotional and physiological stress.

There has been a growing body of literature on stress since Cannon (1929) and then Selye (1956) showed that our body has to remain in a state of equilibrium, or homeostasis, and that any factor physiological orsychological can disturb this balance and create stress. Psychosocial measures of stress have first concentrated on the degree of social disruption that a person experiences after a stressful event. Holmes and Rahe (1967) devised a scale of social adjustment where fixed weights were assigned to specific events, such as widowhood or loss of a job. Other factors in adjustment to stress were then identified and surveys were designed to determine whether stress is cumulative through time or specific to one point in time, and whether

stress depends on the importance that you attach to an event, the desirability of the event, your belief that you can solve your problems, or the amount of social support you receive (Paykel, 1973; Pearlin, Lieberman, Menagahan, & Mullen, 1981; Thoits, 1983; Lin, Dean, & Ensel, 1986).

Assessing a Stressful Situation and Selecting Alternatives

W. I. Thomas and D. S. Thomas (1928) said that "when people define situations as real, they are real in their consequences." (p. 572). Your own assessment of a situation is important.

For example, if you are in the hospital and your therapist is late, you may realize that the ward nurse is the person who probably knows why your therapist is late. She may tell you that the therapist had an emergency and will arrive in 20 minutes, and ask you to wait. She may not have told you before because she was busy. So you settle down, read a paper and when the therapist arrives, you proceed with the interviews. You are aware of the therapist's professional obligations, and because of this you have modified and negotiated expectations and performances.

Defense Mechanisms and Patterns of Reaction

But instead of believing that your therapist is late because of professional obligations, you may become unduly anxious: you may believe that the therapist has not come because you are a hopeless case and because she does not like you, or that she is a selfish person who exploits you. But why do you define the situation in those terms?

Defense mechanisms are defined as the rigid and destructive cognitive methods you use when dealing with a stressful situation (Table 2). We have divided defense mechanisms under two headings: escape from reality, and inability to differentiate between self and others. Your assessment of your therapist may become biased when you repress past traumatic memories, such as the anger and guilt you experienced when your mother did not keep her promises, when she did not show up at your birthday parties. You may regress and believe you are still a powerless child and attempt to deny and rationalize your present situation. Or you may displace onto your therapist your repressed feelings of anger and guilt because you do not differentiate between the roles of a mother and a therapist. Because you don't like yourself, you may project these feelings onto your therapist and believe she does not like you.

Table 2. Defense Mechanisms: Rigid and Destructive Cognitive Methods for Dealing with A Stressful Situation

1. Avoidance of Reality

Repression:	Certain painful expectations and performances are suppressed from immediate memory.
Regression:	You retreat to expectations and performances you held at an an earlier stage of development.
Denial:	You refuse to recognize certain expectations or performance.
Rationalization:	You force your expectations to fit your performance.

2. Inability to differentiate between self-expectations and expectations of others

Identification:	You adopt the expectations of another without evaluating whether they are functional for you.
Displacement:	You transfer an expectation that you hold about a person to another or to an object.
Projection:	You attribute to another a derogatory expectation you hold of yourself

But how do you perform when you are angry or feel guilty because your therapist does not show up? Horney (1945) states that a person can move against, toward, or away from people. You may move against people if, when you were a child, you were aware of the hostility around you, and you were blamed if anything went wrong. You may move toward people if you were brought up to feel helpless and preferred to be dependent and lean on others than to be left to your own devices. A third possibility is that you may withdraw from the situation because, as a child, you felt that no one understood you. We have derived the following four patterns of reaction from Horney's comments.

Table 3. Patterns of Reaction: Habitual, Observable, and Unproductive PerformancesWhen Facing a Stressful Situation

Brutalization:	You physically or verbally force a performance on another.
Victimization:	You submit to the performance of another although it is contrary to your expectations.
Self-Brutalization:	You force a pseudo-performance upon yourself: you eat or drink too much, stop eating, or take drugs.
Insulation:	You physically or verbally withdraw from the situation.

We have added a fourth pattern of reaction: self-brutalization. You may feel angry and guilty because, as a child, you did not know who was to blame and so you punished both yourself and others. But your performance is a pseudoperformance because it does not solve your problems.

When your therapist is late and you displace onto her the feelings of anger and guilt you experienced when you were a child and your mother let you down, you respond to her behavior with patterns of reaction. You may brutalize your therapist and insult her when she arrives; you may agree to see her even when she is chronically late; you may seek solace in alcohol, food, or drugs; or you may refuse to see her when she arrives.

Figure 2 sums up the theory. Unmet expectations lead to physiological and emotional stress. You can either assess your situation objectively, modify and negotiate expectations and performances with others and regain your equilibrium, or, because of defense mechanisms and patterns of reaction, you can let your feelings dictate your behavior. In this latter case, not only is your problem not solved, but your stress may actually increase because you worry why you are ineffective.

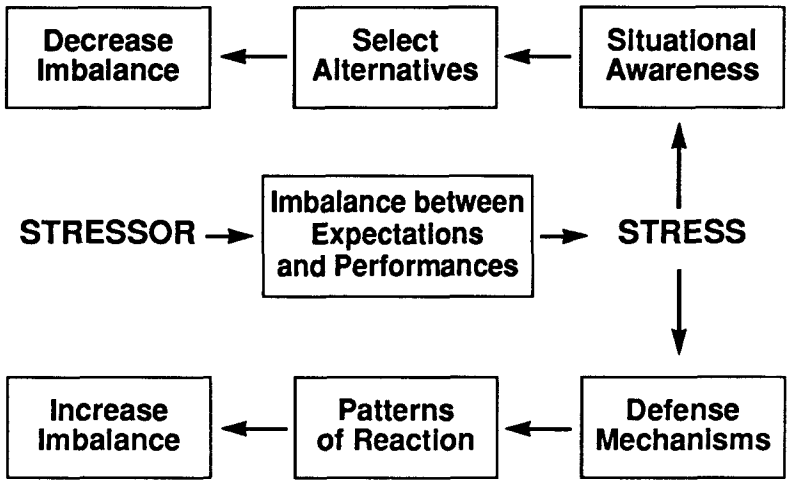

Figure 2. Response to Imbalance in One Life Vector

Methodology and Intervention

The interviews that we developed are therapeutic by themselves because they help the respondents to retrace their life history in a systematic manner. We explain to the patients that we would like to discuss their achievements and not just their problems. We mention that they will be interviewed twice with a structured interview: the first time about their expectations and performances in all life vectors during their last year in high school; the second time about their present situation. In the second interview, we will retrace their behavior from high school to the present in pivotal life vectors such as health, education, occupation and love and sex. We specify that we will discuss with them our theory of alternatives and the results of our interviews.

All the interviews are structured in the same manner. Life vectors are grouped together under the following themes to emphasize their interdependence.

Table 4. Interdependence of Life Vectors

Doing the Work You Like	Taking Care of Your Body
Education	Nutrition
Occupation	Exercise
Speech	Health
Options in Saving and Spending	Be Part of This World
Finance	Art
Housing	Politics
	Law
To Love and Be Loved	At Peace With Yourself
Social Life	Ethics
Love and Sex	Religion
Your Children and Their Future	
Parenthood	

Before they are interviewed for the first time, patients are asked to complete a self-report psychological test, the SCL-90 (Derogatis, Lipman, & Covin, 1976). It consists of 90 questions rated on a five-point scale

Each interview takes about 50 minutes to complete. Patients are asked to describe their behavior in each life vector and evaluate their relationships with significant others. An attitude question guided by the critical incident technique (Flanagan, 1956) is asked for each life vector to determine whether a higher number of life vectors in which patients have an imbalance between expectations and performances results in a higher level of stress, as measured by their SCL-90 test. Attitudes are scored on a 4-point scale ranging from very important to very unimportant. Patients are scored as having an imbalance in one life vector if a critical expectation is not met.

To determine their mode of response to stress and to measure their patterns of reactions, the respondents are asked questions dealing with their relationships with their loved ones, their parents, their boss, and their coworkers

At the beginning of their third interview, the theory of alternatives is explained to the patient, using visual models. Then the social summary of their interviews is discussed with them. This summary lists the life vectors that they consider very important; the life vectors in which they have serious problems according to our cultural criteria and their own evaluation; and the conflicts and priorities that they have indicated are of concern to them. A

quantification of their patterns of reaction and their total score on the SCL-90 test are included in the summary.

Parents or spouses are interviewed with interview schedules based on the same model as the second interview with the patients. During their second interview, their own social summaries and the patient's social summary is discussed with them.

A confrontation between patients and significant others takes place after each respondent has seen the social summaries of the other members of his family. This confrontation helps the respondents to take the role of the other (Mead, 1934). The patient then discusses his goals and priorities with family members. Differences of opinion are resolved and family roles restructured.

We have tested the main propositons of the theory on a sample of 80 schizophrenics and depressed, alcoholic, or anorexic patients and their relatives, a follow-up group of 16 outpatients, and a control group of 347 university students. We have found that the patients' level of stress is related to the number of life vectors in which they have serious problems according to our cultural criteria and their own evaluation (Ferguson, et al., 1991).

Our biopsychosocial role theory allows the patients to integrate the insights of psychodynamic, cognitive, and interpersonal therapies. The concept of life vectors and our interview schedules help the respondents to retrace and identify the traumatic incidents that have biased their appraisal of their present situation. The distinction which we make between expectations, feelings, and performances allows the respondents to become aware of their method of structuring and interpreting their experiences. They learn to monitor their defense mechanisms, and to differentiate them from their patterns of reactions. Instead of mourning their losses forever, they become intent on developing their sense of attainment and solving interpersonal disputes.

We are in the process of writing a book, "Taking Control of Your Life," which explains in detail the development of the theory of alternatives, the construction of our interview schedules, and the therapy based on this model.

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Understanding Paranoia: Toward A Social Explanation

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ABSTRACT

In this paper we seek to offer an essentially sociological explanation of paranoia by way of a detailed examination of the case of an unmarried, ex-school-teacher who for the past 30 years has clung stubbornly to the belief that she is the victim of an ill-defined group of conspirators with the power to control her thoughts and actions. Taking as our starting point Lemert's seminal 1962 paper, we argue that paranoia is best understood, not as a disease in the accepted medical sense, but rather as a desperate attempt on the part of the sufferer to protect self from the consequences of a public identity at odds with self-image, and that its origins are to be sought in a combination of frustrated ambition, persistent failure and emotional isolation

In this paper we set out to account for one particular form of mental disorder—paranoia—using an explicitly sociological perspective. We argue that the tendency, of even the more sociologically sophisticated medical writers to view the phenomenon as a disease located primarily in the individual inevitably reduces the social to the biological or psychological, and

unhappily has obscured some important insights derived from clinical practice. Our intention is not simply to rescue social factors from the marginal position to which they have been consigned in so much of the psychiatric literature, but to reassert the power of sociological theorizing in the understanding of human behavior, including aberrant behavior.

Our explanation of paranoia does not assume an underlying disease. This is not to deny the presence, or possibility of bio-physical morbidity. We do, however, suggest that such morbidity is largely irrelevant to the events typically surrounding the "disease" and is unnecessary to any sociological explanation, except in so far as the concept of "disease" is used as a means of accounting for the paranoid behavior, both by the paranoiac and by various authorities (medical, legal etc.). Our explanation focusses on a social process emerging through time and space via behavioral and cognitive activity in which the use of language and symbols play a crucial part. We specifically address the account offered by the paranoiac (more commonly dismissed as "delusions"), as well as the accounts proffered, and preferred by others, doctors especially. Our interest is in the symbolic construction of paranoia—both by the paranoid person and by society at large.

In taking this position we should perhaps make it clear that we are not allying ourselves with the so-called "anti-psychiatry" movement. We do not believe that paranoia is merely a social category, invented by an authoritarian social system and deployed by the medical profession as a means of social control. Paranoid behavior is real enough, and to be drawn into the bizarre world of the paranoiac can be a frightening, or at least, extremely disconcerting experience. When they turn nasty—either physically or legally—as they often do, intervention is necessary, not, as we will argue, for authoritarian, but for humanitarian reasons; that is, generally with the best interests of the paranoiac, as well as others with whom s/he is engaged, in mind.

Psychiatry and the Concept of Paranoia.

The phenomenon which concerns us has been variously described as "paranoid disorder" (A.P.A., 1980), "paranoid reaction" (Batchelor, 1969; Cameron, 1959), "true paranoia" (Bonner, 1951), or "paranoid state" (Freedman, Kaplan, & Sadock , 1972). All refer to a disorder that is characterized by the appearance of chronic and intractable delusions of a grandiose, erotic, or persecutory nature, but in which other psychological functions, such as memory, consciousness, affect, intellect, and personality,

remain well preserved. Psychiatrists typically approach paranoiacs with a well-founded pessimism:

> The prognosis of well-established systematized paranoid delusional states is extremely serious. It is very seldom that such cases ever make an adequate, or satisfactory adjustment, irrespective of any form of treatment which may be employed. A person so affected believes that he is right, that he is justified in his beliefs, and that anyone who opposes his point of view is behaving maliciously, or at least non-understandingly towards him. The illness in most cases runs a more or less autonomous course, with gradual worsening and increasing alienation from others. (Batchelor, 1969 p. 306)

Within psychiatry there is some reluctance to accord paranoia the status of a separate disease entity. In the nineteenth century, for example, dispute over the "paranoia question" divided German psychiatry. The French have never been happy with the term, while British psychiatrists, as Lewis (1970) has noted, prefer the more non-committal adjective "paranoid."

This uncertainty arises in part from the obvious presence of paranoid ideas and behavior in what are clearly other, well defined forms of illness or states, such as in paranoid schizophrenia or substance abuse. In DSM III, however, paranoid disorders are recognized as complete and separate entities quite distinct from paranoid schizophrenia (A.P.A., 1980). Batchelor (1969), too, argues that the paranoid psychoses can be distinguished from schizophrenia in terms of sex, age of onset, social class, personality, and the absence of many symptoms commonly found in the latter condition, such as incoherence of thought, incongruity of affect, volitional disorders, and catatonic symptoms.

Given the confusion over the definition, and even the existence, of paranoia, it is hardly surprising to find little consensus on matters of etiology. At one extreme are the psychoanalysts, who, although a diverse bunch, are at least agreed that the problem resides in intra-psychic processes originating in early childhood (see eg., Freud, 1927; Glover, 1949; Klein, 1932, 1948, 1961; Meissner, 1978; Winnicott, 1958). Their work, and that of their followers, has produced many detailed case studies that have yielded valuable insights, especially into the family dynamics involved. Yet too often couched in overly reductionist and opaque terms they frequently stand accused of explaining everything, and therefore, ultimately nothing. Quite different in both style and substance is a body of research that eschews theory for a more cautious listing of traits, characteristics or fac-

tors predisposing to, or in some way linked with, paranoia, but whose etiological significance remains for the most part associational. Between these extremes is a voluminous literature of varying ambition, theoretical sophistication and explanatory coherence (see especially, Cameron, 1943a & 1943b; Swanston, Bohnert, & Smith, 1970). A detailed review of this work is beyond the scope of this paper. Here we will content ourselves with a number of general observations, whose sweeping nature we freely acknowledge, but which we would argue apply, to a greater or lesser degree, to all (or perhaps more advisedly, since we are dealing with an extremely heterogeneous body of work, almost all) psychiatric writing on paranoia.

First is the tendency to locate the problem within the individual. Some writers intend this quite literally, while others imply a more metaphorical usage and take a wider view of causation and responsibility. But the appeal is ultimately and invariably to some unpleasant attribute or condition that in someway attaches itself to the individual. Whether the villain is a malfunctioning brain cell, some psycho-sexual trauma of early childhood, or a particular constellation of personality factors, the clues to the problem lie buried deep within the individual, recoverable only with professional assistance. It is this commitment to individualism that prevents a shift away from the medical model towards a more thoroughly social explanation. At the same time, it reinforces the tendency to view as disease, or at least as the symptoms of disease, what may more usefully be seen as strategic behavior.

Second, the body of work we refer to contains a highly deterministic model of human action. Paranoiacs, and by extension, human beings generally, are portrayed as creatures driven inexorably toward their destiny—by biological processes, inner psychic forces, or external circumstances. The particular variables and their precise relationship to each other in the causal chain are of little consequence compared with the general commitment to this principle of determinism. The possibility that men and women as essentially rational and purposeful actors might exercise a degree of control, not only over their environment but also over their own natures, and that action might involve choice from a variable range of options, is largely discounted.

Third is the assumption of pathology; that unpleasant conditions (in this case paranoia) must have equally unpleasant antecedents (such as a stunted or distorted personality, over-demanding or repressive parents, or a conflictual family life). Of course all this follows from the decision to treat paranoia as a disease or illness similar in all general respects to any other disease or illness known to medical science, with its own clearly defined and recognizable cluster of signs and symptoms, and located, in the final

analysis, whatever exogenous influences it may be subject to, within the individual sufferer. It is precisely this concept of paranoia which we regard as unhelpful and which we wish in this paper to challenge.

The account of paranoia that we advance rests on a fundamentally different model of human action and conceptualization of the phenomenon from the one that lies buried within so much of the literature on the topic. We hold that social action (or behavior) is an extraordinarily subtle and complex phenomenon which requires for its competent enactment a number of delicate skills. It is in the first instance oriented to its immediate social context. Above all, we believe that behavior cannot be understood without close inspection of its cognitive component, since it is in the process of defining and naming that human actions are given meaning, enabling us to classify them as of this or that type. Because, whatever else it is, paranoia is a form of social behavior, defined essentially in terms of deficient, or threatened, social relations, we would expect to locate its genesis and development in the network of relationships and interaction patterns that constitute the sufferer's social world.

The one author who has attempted to construct an explanation of paranoia in these terms is the American sociologist, Edwin Lemert, and his remains the classic—indeed virtually the only—sociological statement on the subject. Lemert (1967) insisted on the need to shift the focus of interest in the study of paranoia "away from the individual to a relationship and a process." In doing so, he argued, "we make an explicit break with the conception of paranoia as a disease, a state, a condition or a syndrome of symptoms" (Lemert, 1967, p. 198).

Although Lemert makes some characteristically insightful comments on the genesis of paranoia, his paper focuses more narrowly on its development and persistence. This distinction, which is clear in his paper, serves to remind us that in much of the writing on paranoia there is a tendency to conflate what are essentially three related, but analytically separate, questions. First, what conditions (or social factors) trigger the behavior? Second, why, when faced with these conditions, do some individuals, but not others, respond in a paranoid fashion? Third, why does the behavior assume the form and course that it does?

Overwhelmingly, the concern in the psychiatric literature has been limited to the second of these three questions—why do certain individuals, but not others, behave in a paranoid fashion—a preoccupation that neatly incorporates the twin features of individualism and determinism. But, we contend, not only does this fatally distort the phenomenon being investigated, it also presents an inappropriate and misleading model of explanation that ignores the fact that "patterns of behavior develop in orderly

sequence....(and that) what may operate as a cause at one step in the sequence may be of negligible importance at another step." What is required is a form of explanation that combines "objective facts of social structure and changes in the perspectives, motivations, and desires of the individual" (Becker, 1963, p. 23), and in so doing fully reflects the emergent character of paranoia.

Method: The Case Study

Our argument in this paper proceeds from a detailed examination of a single case history. The case in question is that of an unmarried former school-teacher (whom we shall call Ms. Tennant) who in 1978 was admitted to the psychiatric unit of a large general hospital with a diagnosis of paranoid psychosis. She was then in her early 50s, and with both parents deceased, living alone. In appearance she was very much the stereotypical "old maid": she wore no make-up, and with her greying hair always severely pulled back in a bun, she had at times a rather imperious look. Her clothes were drab and old-fashioned, and seemingly deliberately designed to deny her sexuality; she wore "sensible," lace-up shoes, thick woollen stockings, voluminous, ill-fitting skirts, and usually two or three sweaters or cardigans—"a walking yard-sale" was how one junior doctor, perhaps unkindly, but not inaccurately, described her.

This lady maintained (and continues to maintain) that she was the victim of a malicious, yet ill-defined conspiracy, which destroyed her career and ruined her life. The details of this "plot" are not easily grasped, as the contents of the delusions seem to assume different forms at different times, probably reflecting her current concerns and worries. The essential elements, however, remain unchanged. The conspiracy is organized by a shadowy group of nameless individuals, whose identity is uncertain—even, apparently, to Ms. Tennant herself. It is not clear whether she has ever seen them, or indeed would recognize them if she were to encounter them. All her talk, however, implies that they do assume an incarnate form, which does at least lend her story an immediate plausibility. Acting, wittingly or unwittingly, as agents of the main conspirators is a vast, and again ill-defined, army of "proles" (a term borrowed from Orwell to suggest the nightmarish quality of her situation). The "proles" are recruited from the very real people she meets in her daily life—neighbors, colleagues, tradesmen, doctors, etc. Ms. Tennant firmly believes that the conspirators, and perhaps their agents, have the power to monitor her actions, private conversations, and even her thoughts. To guard against this and its terrifying

implications she must exercise a constant vigilance and resort to all manner of devious, and outwardly bizarre, strategems.

The case first came to our attention upon Ms. Tennant's admission to the hospital. In the course of her stay, she struck up a relationship with one of the present authors (DM). This relationship, which continued long after her discharge from the hospital and, later on, from psychiatric treatment altogether, was to prove more intensive and enduring than any she had previously experienced (excepting, perhaps, that with her parents). For the six years, the two met on a weekly basis. Later, following a six month sabbatical break, the meetings were reduced to one a month. In total, DM has spent more than 300 hours talking with Ms. Tennant. Detailed notes were kept of their conversations, especially in the early years. Tape-recording was, for obvious reasons, not possible, and note-taking generally had to proceed circumspectly. Ms. Tennant's talk assumes a repetitive, circuitous, frequently allusive, and always guarded character, which makes it difficult at times to follow or immediately grasp its meaning. For this reason, an attempt to produce a chronological account of what was said during the course of each session was soon abandoned as it proved too time-consuming and confusing. Instead, notes were organized around particular topics that had arisen in the course of the discussion.

The meetings with Ms. Tennant were initially prompted by a more general, if somewhat vague, interest in patient perceptions of psychiatric treatment. While sociological concerns remain at the center of what is a continuing involvement,—and we offer this paper as some proof of that claim—the relationship (inevitably so, given the lady's preoccupations and our methodology) has been transformed into a quasi-therapeutic one. This, of course, raises important ethical and methodological issues that we cannot deal with here beyond acknowledging their existence. We do, however, wish to point out that while we have never discussed the nature of our sociological concerns with Ms. Tennant—in part because she has not shown the slightest interest in them, and in part, too, because these concerns have genuinely evolved over time and have not therefore been wholly accessible even to us—she is under no illusion that she is speaking to anyone other than a sociologist, who lays no claim to any psychiatric expertise or therapeutic competence.

Whether or not Ms. Tennant is a typical paranoiac is not relevant to our purpose or our method. Indeed, whether in fact she is "really" paranoid at all (whatever that might mean) does not particularly concern us. It is sufficient for our purposes that two highly competent psychiatrists on separate occasions came to the conclusion that she is. As Mitchell (1983, p. 190)

has convincingly argued, in case studies "extrapolation is in fact based on the validity of the analysis rather than the representativeness of the events."

The version of Ms. Tennant's life that we present in this paper has been derived almost exclusively from what she alone has told us (although that does not necessarily make it her account), supplemented with data taken from her case notes. We have made no attempt to seek out the views of those—family, friends, neighbors, colleagues, doctors, social workers, and others (although we have talked extensively to her psychiatrists)—who, over the years, have been drawn into Ms. Tennant's world. We acknowledge this as a serious weakness, but plead sound practical and ethical reasons for our decision. In the end the validity of our account rests largely on appeals to plausibility, and in crucial places to the internal consistency of the evidence. We do, however, contend that our explanation accounts for most of the known 'facts" in this case, enables us to predict how Ms. Tennant is likely to act, and provides a basis for her continuing management. We are not sure that in practice more can be asked of explanations than this.

Case

Origins

Ms. Tennant was an only child of elderly parents. Her mother, who had had a number of miscarriages, was aged 40 when she was born. Her father, having spent some time in the British army, was then serving as an officer in one of Scotland's more forbidding pre-war prisons. Her childhood and adolescence coincided with the "Depression" years and World War II, and some of the austerity of that period seems to have rubbed off on her. Her family was fairly comfortably placed, however, and there is no evidence that she suffered particular hardship or, more generally, that her upbringing differed markedly from that of any other girl of her time or place. While difficult to judge from this distance, her parents seem to have possessed all the virtues, and faults, of the Scottish middle classes: hard-working and self-reliant; strong on discipline and self-control; overly concerned with appearance and respectability; and above all, possessing a well-defined sense of what is right and proper. Her father, especially, appears to have been somewhat aloof and authoritarian, but again no more so than any man of his generation and background. Not unnaturally, Ms. Tennant developed a closer relationship with her mother. While neither parent was much given to open displays of emotion, they seem, nonetheless, to have cared deeply

for their daughter. However, when her paranoia first manifested itself in symptoms that could no longer be ignored (a necessary circumlocution because it is in the nature of paranoia that its onset cannot be precisely identified), both were then in their seventies; and, although clearly distressed and bewildered by what was happening, they no longer had the intellectual or physical powers to offer much practical help.

Ms. Tennant apparently was an intelligent child and much was expected of her, not least by her parents. But upon leaving school at age 17, having done reasonably well in her examinations, she drifted rather aimlessly for a time, much to their disapproval. There was a succession of mostly "dead-end" jobs, and at least two periods working and living away from home. However, she seemed to have put all of that behind her when at the age of 21, and much to her mother's satisfaction, she gained a place at the University.

The picture that emerges of Ms. Tennant at the University is an ambiguous one. Although she continued to live at home, her circle of acquaintances widened and her social life took on a new depth. She even appears to have "dated" occasionally, although not on a regular basis; photographs taken at the time show her to have been a not unattractive young woman. On the other hand, there is some evidence that even then her behavior was regarded as somewhat strange by her contemporaries and that she remained a marginal, socially isolated figure.

All of us from time to time are prone to misconceptions about the nature of the world around us and our place in that world. For the most part this is not too disastrous because as we tentatively test our interpretations in the company of close friends and family, we are encouraged and enabled, usually without too much fuss or mortification, to revise them and bring them into line with the views of others. This is such a subtle process that we are rarely conscious of it, but as Berger (1963) has noted, it is crucial to the construction and maintenance of a viable sense of self:

> Identities are socially bestowed. They must be socially sustained and fairly steadily so. One cannot be human all by oneself, and apparently one cannot hold onto any particular identity all by oneself. (Berger, 1963, p. 118)

Lacking close, confiding relationships, Ms. Tennant turned instead to 19th century literature and the cinema for her role models. In these circumstances, it is hardly surprising that the persona that emerged as she entered adulthood was both distorted and deficient, concealing a highly romantic, yet unrealizable self-image.

Failure

Lemert has suggested that the origins of paranoia are to be found in "...persistent interpersonal difficulties between the individual and his family, or his work associates and superiors, or neighbours, or other persons in the community." In turn, these difficulties frequently center on some actual, or perceived, status loss or failure, "which may appear unimportant to others," but whose "unendurability...is a function of an intensified commitment, in some cases born of an awareness that there is a quota placed on failures in our society." (Lemert, 1967, p. 201)

Ms. Tennant was soon brought face to face with failure in both her professional and private life. At the University, after some initial success, things quickly began to go wrong. She failed her examinations, was forced to change courses, and struggled to get her degree. This was a bitter blow. Intellectual ability is for Ms. Tennant an important source of self-esteem. While she might not possess the charm or social graces of other women, she had always considered herself more clever than most. Her university experience made it increasingly difficult to sustain that illusion.

She left the University as a qualified teacher, but could only get a job in the City's primary schools (for children aged 5-12 years), which at that time attracted few graduate teachers. Yet even in this less demanding environment, she conspicuously failed to make progress. Despite being better qualified than the majority of her colleagues and, despite her uninterrupted service (many were married women who came and went), she was not promoted, but instead continued to be assigned the less important, and less taxing, junior classes. The implications of this, for both her ambition and reputation, were not lost on her.

While she denies it when it is put directly to her, all the evidence, going right back to her teaching days, suggests that she found the work a great strain, which intensified as her incompetence and failure became increasingly manifest. Certainly, it is very difficult to imagine such a withdrawn and essentially private woman enjoying teaching, or being very good at it, since it is a job that can punish the introvert in many ways.

Nor was Ms. Tennant's perception of failure restricted to her professional life. For Ms. Tennant, the normal pattern of a woman's life is to marry and raise a family. Her mother had apparently encouraged her to go to the University in the hope that there she might "make a good match." Indeed, Ms. Tennant seems to regard the ability to attract men as constituting the visible, public proof of one's standing as a woman. Now as she entered middle-age, still unmarried, this too was a fast receding ambition.

The Crisis

Matters came to a head for Ms. Tennant early in 1961. She was then aged 34, and had been teaching for some 10 years. While it is difficult to piece together the precise chronology of events—the intensity of the experience is reflected in the opacity and incoherence of Ms. Tennant's accounts—the problem seems to have manifested itself initially in difficulties at work. Teaching, as Willis has noted, is an occupation all too likely to give rise to paranoid fantasies:

> Teachers are adept conspiracy theorists. They have to be. It partly explains their devotion to finding out "the truth" from suspected culprits. They live surrounded by conspiracy in its most obvious—though often verbally unexpressed—forms. It can easily become a paranoiac conviction of enormous proportions. (Willis, 1977)

The chain of events that would eventually lead to Ms. Tennant's breakdown began with the sudden departure of one of her colleagues midway through the spring term. Ms. Tennant was required to absorb part her former colleague's class into her own, exacerbating the problems of order and control she was already experiencing. Some weeks later she heard that she had again been passed over for promotion. It was about this time that she seems to have first experienced the "monitoring" and "dialogue" which so unnerved her.

Returning to school in the fall, her classroom problems continued. She was, moreover, becoming increasingly isolated from her colleagues. It is suggested that she was the object of much gossip. Some staff, in fact, even complained about her to the headmaster. Certainly by this time she had become the subject of comment and concern. She responded by withdrawing more and more from contact with her fellow teachers. She avoided the staff-room, remaining in her own room at break-time. This only increased her alienation, and no doubt strengthened her colleagues' view of her as someone who, to say the least, was a little strange.

As the weeks and months passed, Ms. Tennant's paranoid symptoms became increasingly florid. The winter of 1962-63 was particularly difficult. The weather was bad, and just getting to and from school was not easy. She became ill with the flu and felt wretched as she struggled to hold down her job as well as look after the house and her aging and ailing parents. She was unwilling to take time off from work for fear that the authorities might seize the opportunity to dismiss her. She describes her life at this time as a "nightmare." It was at this point that she took her complaints

to the headmaster and demanded that he act to put a halt to what she perceived as the malicious behavior of her colleagues.

Allocation to Paranoid Status

Crude labelling theory notwithstanding, social groups can show a remarkable tolerance for deviant or norm-violating behavior. As Lemert (1967) has observed, the typical response to paranoia is avoidance. Moreover, what brings about formal intervention is not the content of the paranoiac's story as such, but the persistence, and indeed the insistence, with which it is pressed. This is particularly the case where the paranoiac goes to the legal authorities, writes to government departments, or invokes the formal complaints procedures available to a citizen. Once this stage is reached, the paranoiac's accusations can no longer be ignored, evaded, or deliberately misinterpreted for appearance's sake; they must be taken at face value and dealt with accordingly.

In Ms. Tennant's case there is evidence, extending over a period of at least 18 months, of increasingly bizarre behavior and an inability to discharge her duties effectively. For example, she describes how during this period her problems would so completely overwhelm her that she would break down in class, weeping uncontrollably at her desk, while the children were left to their own devices. It is inconceivable that reports of this behavior did not get back to the headmaster, or to the parents. While this seems to have prompted closer surveillance of her activities by senior school staff, a move that of course fueled her paranoia, it brought no formal intervention; it was, ironically, left to her to initiate that.

Once she had taken this step, events moved with bewildering speed. She was referred, via the school doctor and her general practitioner, to a consultant psychiatrist, who diagnosed "a paranoid reaction with secondary depression," a label she sought, if not openly to challenge, then at least to resist. She refused even to have the phrase "nervous exhaustion" on her sick-note, eventually persuading her general practitioner to substitute the diagnosis of "anaemia." She attempted to conceal the identity of the psychiatrist from her parents by telling them that he had come to see her about her varicose veins. Throughout her first period of sick leave she declined to accept the state benefits to which she was entitled because she simply did not concur with the definition of herself as sick.

Whether she was genuinely bewildered, or simply engaged in a futile attempt to compel others to accept her definition of the situation, the true nature of her position was starkly and embarrassingly revealed to her not long after the psychiatrist's visit. A letter from him, in which he set out his

diagnosis, was delivered, not to the general practitioner for whom it was intended, but to Ms. Tennant herself. Until this point, those who had been dealing with her had merely hinted at what they really thought was the matter: she was "ill," "under strain," "experiencing difficulties at school," and "heading for a nervous breakdown." No one had yet said to her (understandably enough) that she was "mad," "deluded," or "paranoid." Receipt of the psychiatrist's letter presented Ms. Tennant with a version of herself that was difficult to avoid. It also provided her with proof of her suspicions regarding the duplicity of the authorities. Her belief in a conspiracy was reinforced.

From Diagnosis to Hospitalization

Following an extended period of sick leave, Ms. Tennant returned to her teaching job, but at a new school. Her reputation and problems followed her, however, and she was soon as estranged from her colleagues there as she had been in her previous position. Intermittently, over the next 15 years, she continued medical treatment, alternating between her own general practitioner and the psychiatric outpatient clinic. While this offered temporary alleviation, it failed to reverse the inexorable deterioration in her situation and personality. Doctor and patient remained forever at cross purposes as this "cri de coeur" from her GP reveals only too well:

> ...[S]he kept breaking into denunciations of the staff at her former school with detailed, pointless stories about the way they had treated her. All I could do was to advise her to forget the unhappy past and concentrate on the present and future. I also offered her some tranquilizers, which she refused.

A medical diagnosis offered much more than an explanation for Ms. Tennant's behavior, or a way out of an increasingly uncomfortable situation for the school authorities. By assigning her to the category of patient, it effectively denied her other forms of redress and resolution, since (except in cases thought to require an exceptional public and symbolic response) medical definitions have primacy over all others and are virtually unchallengeable (Bittner, 1967). Yet, while doctors were trying, and failing, to reach her, Ms. Tennant sought a resolution to her problems on her own terms, taking her case to (among others): her minister, lawyer, member of Parliament, local and national union officers, Director of Education, Social Work Department, Citizens Advice Bureau, Ombudsman, Scottish Office, and the Home Secretary. While always politely and sympathetically

received, she invariably found herself back in the arms of an increasingly despairing medical profession.

There is a discernible pattern to her life in this period: a recurring cycle of illness, remission to barely tolerable levels, then illness once again. With each attack, her position worsened and became, in her own words, increasingly "untenable," and less and less amenable to medical, or indeed any other kind of help. Moreover, the strategy which she had fashioned to cope with her difficulties, namely progressive withdrawal from social contact, served only to exacerbate the very problem it was intended to control, speeding up the next attack, and ensuring that when the attack did come, its effects were all the more devastating.

The crisis which finally precipitated her hospitalization came in 1978, 16 years after the public onset of the paranoia. She was then in her early fifties. By this time her situation had indeed become desperate. Her isolation was virtually total. She had dropped her few remaining friends. Her mother, who had suffered a stroke in 1960 and was thereafter a semi-invalid, died in 1968, and her father 3 years later, although by that time he too had long since been consigned to the army of "proles." She had no television. Her radio was rarely on; her daily newspaper went unread. She had withdrawn into one room of her old house, where she kept the curtains tightly drawn to prevent those who were "monitoring" her from spying. She took little food, and was on the verge of a complete physical break-down. It was at this point that she was persuaded to accept a visit from another psychiatrist. The diagnosis of paranoid psychosis was reaffirmed. Very reluctantly, she agreed to submit to further outpatient treatment, and even to accept medication. Six months later, as her condition deteriorated further, she was admitted to the psychiatric unit of the local hospital.

Conclusion: The Sociological Dimensions of Paranoia.

Two features of paranoia make it an especially interesting subject for sociologists. First, it is revealed almost wholly in talk. It is not simply that talk provides the evidence (symptoms) for the illness, but that the illness itself is talk, and, moreover, talk that is unacceptable in content rather than form (unlike, for example, schizophrenia). Certainly the paranoiac will frequently manifest eccentric, even bizarre behavior, but, as Lemert (1967) has convincingly argued and we have tried to show, this is better understood as epiphenomena, the consequences of inhabiting a social world in which one is defined as paranoid.

Secondly, despite its clinical rarity, paranoia is endemic to our modern world. We are all a little paranoid at times. Indeed, we would go further: feelings of persecution, self-reference, suspicion, and jealousy can reasonably be viewed as both normal and to some degree functionally useful. To be skeptical of the motives and claims of others is one way of preserving personal and territorial integrity, and at the very least protects us from charges of naivety. A certain amount of egocentrism is essential for normal social intercourse and the fashioning of a sense of self. But in the normal course of events, skepticism rarely turns into blanket and unremitting suspicion of everyone, and self-reference generally stops short of grandiosity. Sooner rather than later we are rescued from whatever delusions might momentarily grip us by our connectedness to the social world. Such transient paranoid episodes generally leave us unmarked, our psychic structures intact and our status unaltered.

Sociologically speaking, the underlying "causes" or "reasons" why certain individuals go on to exhibit paranoid behavior of the clinical variety are unknowable since they lie buried in early experiences and relationships not readily amenable to sociological enquiry. The existing psychoanalytic literature and the family-dynamics approach to paranoia, as well as many clinical reports are strongly suggestive of an etiological process having its genesis within the family. It would seem that certain types of family life create in children and adults habitual ways of thinking about, and acting upon, the world, which seem to predispose them to paranoid behavior. These characteristics include behavior which is dominated by uncertainty and ambiguity, and ambivalent relationships. Where family members neither say what they mean nor mean what they say, and where, therefore, hidden meanings and unstated assumptions abound, mistrust is engendered and coping involves a constant search for the hidden meanings underlying external appearances. In a slightly different vein, authoritarian and rigid families produce lowered self-esteem, fear, and high degrees of self-reference, Both sets of conditions form the seed-bed in which "delusions" of persecution, grandiosity and jealousy all thrive. Families which exhibit these varying characteristics populate the literature on paranoia (Anthony, 1981; Bonner, 1951; Kaffman, 1981a, 1981b; 1983; Kaplan & Sadock, 1971; Polatin, 1975). Put someone who has learned to think in these ways in an environment beyond the immediate family which is relatively stable, where meaning can be taken-for-granted, where threat is not ever-present, and the result is likely to be a marked disjunction between self and the external world: enter Lemert and Ms. Tennant.

In this article we have suggested that paranoia arises out of a combination of frustrated ambition, persistent failure, and emotional isolation, all of

which, we believe, are present in the case of Ms. Tennant. Fading adolescent dreams and the general failure of performance to match ambition are not easy to come to terms with. Given that paranoiacs are likely to have been socially and emotionally isolated from an early age, they remain largely unaware of the near universality of that experience; their tragedy is to think of themselves as special. The paranoia not only accounts for their failure, it confirms their specialness. Abandoning the role of participant for that of observer, the paranoiac's frustrated ambitions are redirected to the production and validation of a world view at whose center they are themselves located. Cut off by inclination and behavior from everyday social interaction, the delusions become more firmly entrenched, the commitment to them (both of time and self) the greater, provoking in turn an increasingly systematized response from those groups and individuals with whom the paranoiac comes into contact and leading to further exclusion and isolation.

This is the point at which self and identity intersect. In Ms. Tennant's case, her experiences at school, the failure to be promoted, suspension from her teaching duties, the medical diagnosis, and admission to the hospital, all constitute critical events in the process of negative identity construction. The record of her experience contained in her hospital notes and in the letters written about her by the school authorities and her doctors reveal the labelling process in which her public identity as a mentally ill person was articulated. But while she recognized the social reality of this process, she refused to accord it legitimacy. The irony is that in so doing, she only furnished further proof of her illness.

Our argument proceeds from a rejection of paranoia as a disease or condition that is in some way independent of the social context in which it arises. Far from being a manifestation of a pathological process or an altered psychic state, paranoia may be better understood as a desperate, and ultimately destructive, attempt to protect self from the consequences of a public identity at odds with self-image. Ms. Tennant's paranoia was, we maintain, a response to the problems she experienced in her work as a teacher. It was subsequently exacerbated by a series of perceived failures and crises, by no means confined to her career, that extended over much of her adult life, but which came to a head in early middle age (as such generalized failure is wont to do). Her "illness" functioned to excuse those failures by explaining, at least to her own satisfaction, why she had not achieved all that she and others might have expected. At the same time it legitimated her refusal to do anything about those "failures," for how could she be expected to deal with such problems when all her energies must be directed at the immediate and overriding task of surviving the persecution?

More conventionally we may also view Ms. Tennant's paranoid behavior as "a cry for help." A central dilemma which she faced—and one which may go some way to explain her peculiar resistance to treatment—is that only apparently as a "mad" woman was she taken seriously; sane, no one seemed to care very much about her. It is surely no coincidence that she exhibited few paranoid symptoms during her time in the hospital, a time when she was receiving a great deal of care and attention. Yet less than a week after discharge, an event the symbolic significance of which was underlined by unintended signals from several key figures involved in her treatment (her ward sister, psychiatrist, research sociologist) suggesting that they too had lost interest in her, she sent off a highly paranoid letter to the Home Secretary.

All of this merely illustrates the secondary gains which attach to any occupant of the sick role (Parsons, 1951). Appealing to illness as a means of solving problems, gaining attention, being cosseted, or to escape reality is well documented (Gerhardt 1979; Herzlich, 1973; Lipowski, 1970). Such "tactics" are by no means confined to paranoiacs or to the mentally ill. They have, of course, profound treatment implications, suggesting as they do good reasons why the sick person might acquire a considerable investment in the continuation of his/her illness (Scott, 1973). In this sense medical definitions are not neutral, for though they promise treatment and care, they do so only on the basis of the continued existence of that condition which the treatment is intended to eliminate.

Central to our analysis is the status of the account offered by Ms. Tennant. In a paper which considers some of the methodological issues associated with the validity of accounts produced and used qualitatively, West (1990), following Cornwell (1984), draws a distinction between public and private accounts. Public accounts are those produced by subjects which affirm or reproduce the moral order or dominant ideology. These are "ought" types of expressions of an approved or acceptable kind. Private accounts, on the other hand, refer to meanings derived from the experiential world—a reality often at odds with the public account of things. As West notes, with reference to people with long-term, non-psychiatric illness, such subjects are "eminently capable of talking about an issue in different, and apparently contradictory ways," and shifting from private to public accounts as the situation demands. What distinguishes Ms. Tennant's account of her "illness" from those produced by other chronically ill people (see, e.g., Kelly, 1991, 1992a, 1992b) is that it only has the private quality. She is unable to shift into a personal account which incorporates a public social order. While she clearly recognizes that social order—her identity as "sick"— she is unable (or unwilling) to incorporate it to any sig-

nificant degree in what she says or does. It is this "monotonous" nature of the account which distinguishes the paranoid person from others.

Language and action reflect each other. Both unfold in space and time, inextricably bound together. In this sense language is representative, not of some other underlying phenomena (biological or behavioral), but of the sense of self and the social identity the person doing the accounting is laying claim to. In this sense the form and content of the account is an important element in emergent social action. The sociological enterprise is therefore (at least in part) not to ask why paranoid behavior occurs in the first place; it is to explore and elaborate the unfolding social processes of which language is a crucial part by focussing on the situational and context specific circumstances in which useful social skills become translated into unrealistic fears. Looking for the origins of such thoughts and skills in an earlier developmental phase is simply not on the sociological agenda.

Postscript

Ms. Tennant was in the hospital for 3 months. She left in much better physical condition than when she came in, but with her delusional system intact, indeed untouched. It was not that she offered any great resistance to treatment. Quite the reverse. She was at all times a "good" patient. She never caused trouble or made demands on staff. She always appeared to listen respectfully when advice was offered. She was ever ready to join in conversations, and to mix with her fellow patients, even though she found many of them coarse and uncongenial. She was, in fact, prepared to do all that was demanded of her without demur or complaint. Yet, like her earlier acceptance of psychiatric help, this never involved her in legitimating the treatment she received or the basis on which it rested. She even went so far as to deny the existence of any continuing problem, much to the frustration of nursing and medical staff.

A short period of outpatient treatment followed her discharge from the hospital, but this was discontinued as her life returned to an acceptable level of normality. The contact with the research sociologist continued, but it was at times difficult to see what purpose their meetings served, other than to keep Ms. Tennant in some kind of contact, however tenuous, with a reality beyond her own world. There is a decidedly instrumental quality to all of Ms. Tennant's dealings with the wider world, and suspicious though she was of others' intentions, she was also well aware of the dangers of complete social isolation. From time to time she seemed ready to

concede that her story might lack credibility, but she never went so far as to abandon her claims or the behavior they supported.

In 1989 there was a noticeable deterioration in her appearance and behavior. She turned up for meetings with the sociologist looking particularly unkempt, in clothes that were torn, dirty and ill-fitting. It was clear, too, that she was not eating properly or taking care of herself, and her paranoid symptoms, for so long concealed under an outward show of deference, were becoming increasingly florid and open. Her general practitioner was informed, and closer monitoring of her condition was instituted. Matters came to a head early in 1991. Her varicose veins ruptured necessitating emergency hospitalization. All professionals involved agreed that, under the circumstances, return to her own home was impossible. An alternative place was found for her in a residential home for the elderly. Shortly after her transfer there the sociologist wrote to her offering to reinstitute their meetings. So far that letter has gone unanswered. Reports from the Home suggest that she has settled down well and has so far shown no signs of bizarre or paranoid behavior.

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Deep Learning Groups: Combining Emotional and Intellectual Learning[1]

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ABSTRACT

This article discusses deep learning groups (DLGs) which seek consensually validated truths (intellectual learning) and the experiential understanding of feelings (emotional learning). Deep learning enhances the maturation of DLG members. The theories of Jürgen Habermas, Robert Langs, and Virginia Satir provide the bases for deep learning groups. Using transcripts from two seminars, examples of deep learning are presented. Deep learning is marked by catharses of recognition and release, and results in insights and questions.

Definition: a metalogue is a conversation about some problematic subject. This conversation should be such that not only do the participants discuss the problem but the structure of the conversation as a whole is also relevant to the same subject. . . . notably, the history of evolutionary theory is inevitably a metalogue between human beings and nature, in which the creation and interaction of ideas must necessarily exemplify evolutionary process.—Gregory Bateson

Deep learning groups are metalogues which explicitly incorporate emotions.

Introduction

Imagine that there is a fundamental learning experience. It is at once emotional and intellectual, mental and physical, social and personal, totally unique yet freely shared. There is a communal place where this experience becomes positively energized and charged. This is the kind of experience which I call "deep learning."

This paper presents a theoretical model with examples of deep learning from practice in small groups. Groups such as seminars are usually designed to promote intellectual learning. Emotional learning goes on as well, but this is unacknowledged and/or unconscious. Negative emotions, such as shame, anger, jealousy, and fear may become associated with seminars.

Therapy groups, by contrast, promote emotional learning, with intellectual learning tangential. I have often had the feeling after leaving a group where intense emotional exploration had occurred that I was at a loss to explain to anyone else what was learned, or to transfer the learning elsewhere. In order to effectively transfer emotional learning to another setting, it is vital that learning be connected with a theory, or have a reflective intellectual component.

The kind of intellectual learning I am referring to has a specific meaning. The learning is not a kind of discernment, cognition, knowing, or calculation, although it may include these mental processes. Nor is it equatable to learning a skill or absorbing information. Intellectual learning is an inquiry into meanings and connections. It is a philosophical quest for understanding. It is similar to what Karl Mannheim (1936) calls "substantive" rationality, in contrast to "instrumental" rationality. Instrumental rationality seeks causes and effects and means-ends relationships. Substantive rationality looks at the whole, and seeks a gestalt of meaning, including the full array of values involved in any course of action or event. Instrumental reason seeks to obtain power, to predict and control; substantive reason to understand and to ameliorate.

The knowledge sought in intellectual learning is an interested knowledge. It does not claim ethical neutrality or objectivity. It is knowledge aimed toward the search for eternal values (or, if "eternal" is too grandiose,

a return to classical values) such as goodness, truth, beauty, and justice. Intellectual learning is socially and politically responsible knowledge.

Emotional learning is more simply a love for the fullness of human expression, or awareness of human spirit. Because emotions tend to be ignored in our educational systems, we must reclaim them. As Alice Miller (1984) so eloquently explains, our practices of parenting and of pedagogy are abusive in the extent to which they deny our self understanding of feelings.

Theory of Deep Learning

Thesis: Intellectual Learning in Habermas

The most basic foundation for the group process is Jürgen Habermas's model of the ideal speech situation. The aim of the communicating group in the ideal speech situation is to seek truth—or intellectual learning. The kind of group process which occurs in Habermas's ideal speech situation is utopian. Its purpose is to serve as a model against which to measure actual group practice.

Deep intellectual learning in groups is distorted by power. Since organizations are hierarchies of power, special effort must be made to insulate and protect group processes from the effects of power. "Truth" is not to be taken as an ultimate and absolute, but as the best understanding or interpretation possible for those involved.

Certain conditions must be met for groups to approach Habermas's ideal. Firstly, the agendas must be open. All must have equal access to the floor; all assumptions must be allowed examination; persons must not be punished for their opinions; and strategic communication must be eliminated. Habermas contends that social order depends upon four assumptions which are made in speech acts. These are: truth (what is being spoken reflects an actual reality), truthfulness (the speaker is sincere), understandability (the speaker's symbols and gestures are clear), and comprehensibility (the speech act occurs in a cultural situation where it can be correctly interpreted and assimilated). Without these assumptions being made, communication would be impaired or would break down altogether. Con artists, advertisers, public relations firms, and political campaign professionals all attempt to slant or systematically distort communication to meet strategic objectives. This activity is "parasitic" upon the norms of "competent communication," where the four assumptions are met.

In current society, these communicative norms are systematically distorted by power interests. Mass communication and large scale organizations work against congruent communication. Billions of dollars are spent annually to convince people to purchase products, support candidates, revere the military, and advocate wars and other causes they would not otherwise support (T. R. Young, 1991). Pseudo-communication abounds. If one seeks to establish participatory "competent" communication, one must protect the interactive situation from the damaging consequences of power differentials and strategic motivations.

Individuals may be unaware of their own strategic motivations, due to unconscious dynamics. Habermas (1973) views psychoanalysis as a method to assist in cleansing communicative processes of such interferences. Habermas, like the tradition of critical theory which he follows, uses Freud's theories to explain both the distortions of political communication and the way personal psychopathology can interfere in the creation of a rational community. Emotions seem only to get in the way in this creative process.[2]

Habermas's participatory group process is currently being utilized as a basis for a communicative ethics and for forming democratic work groups in corporations (Gustavenson, 1990). In my research with groups of women making mid-life transitions, I used Habermas as a basis for structuring the groups within the setting of a large university bureaucracy. Very quickly, I looked elsewhere for an understanding of the emotional dynamics which emerged (Bentz, 1989).

Antithesis: Emotional Learning in Satir and Langs

A second major theoretical basis for structuring the group, which integrates emotional and intellectual learning, is the work of Virginia Satir. Unrecognized and unacknowledged emotions negatively effect one's ability to be present and to act effectively and efficiently. Following the lead of Gregory Bateson (1972, see also Rieber, 1989), Satir stresses the importance of congruent communications for self-esteem and good relationships. Congruent communication is defined as being in touch with one's own feelings and verbalizing them in a direct but unaggressive manner. Unlike blaming, placating, objectivistic, intellectualistic or distracting communication, in congruent communication (leveling), one "owns" ones feelings and thoughts and comments directly on the relationships at hand. Historically, families and societies have functioned in incongruent patterns.

According to Satir (1983), in "conjoint family therapy," the therapist acts as a coach and provides an emotional resource. Family members learn to recognize and express their emotions, expectations, and desires vis a vis one another. Satir contends that emotional dynamics in current relationships are continuations of patterns learned in our families of origin. As Thomas Scheff said, echoing James Joyce: "All of history is a nightmare from which we must awake."

Robert Langs's "communicative psychotherapy" (1978) focuses on enhancing leveling between patient and therapist through the interpretation of "derivatives." Derivatives are metaphorical or allegorical statements which Langs sees as indirect commentaries on the relationship at hand. Langs points out that persons often express their feelings about what is happening indirectly, by the use of stories about events or relationships outside of the immediate one. For example, a patient talking about how his wife does not listen to him, his uncle does not return his calls, and his boss is always out of town, may be referring indirectly to his perceptions about the lack of responsiveness of the therapist. Given adequate supportive statements by the therapist, such as references to the therapist having been late, the therapist may offer an interpretation relating this material to their relationship.

Langs tends to intellectualize emotions. His interpretive practice takes place in an atmosphere of allegiance to rigid professional norms of communication based on the suppression of one's own feelings (Langs, 1978). The emotional bonding which occurs in the therapeutic setting is treated only as a tool for analysis.

What is of value to emotional learning from Langs's work, however, is a sensitivity to the derivative meanings of communication (See Langs, 1983). By analyzing the implications of chosen topics for sociodrama, role play, or discussion in the group, members can evoke and realize unconscious fantasies and fears as well as unacknowledged emotions about the group and members in the group.

Synthesis: Deep Learning

The synthesis of intellectual and emotional learning is an attempt to get beyond the false dichotomizations of the two. Emotions are not "error factors," or "disturbances" in a rational process. Rather they are a driving force in social action. Emotions may be expressed, repressed, or sublimated. They may be true or false, spurious or essential, or based on accurate or inaccurate perceptions. Critical reflection is essential in order to tell the difference. Emotions, like intellectual structures, can grow and change.

Deep learning is a process of inquiry involving maturation (See Spotnitz, in Kaplan and Sadock, eds., 1972). It is learning which results in a stronger, more expansive self, which can move back and forth in an increasingly rich inner world, to form mature relationships (See Bentz, 1989, for a model of mature relationships). Deep learning is marked by catharses of tears and laughter, involving both release and insight. The process may often include peaks of anxiety and panic or resolution and calm. the deep learning process leads to clarification and also to new questions. Learners often feel fatigued after a deep learning session, but also feel energized. Part of the deep learning process is an attempt to monitor and include the responses and cues of the bodies of the participants.

Deep learning may include analyses of members' emotional states and family systems. Deep learning integrates theoretical understanding by going back and forth between emotional leveling and the conceptual materials at hand. The whole process is one of research into self and others in the supportive group environment. There is consistent feedback between group members about the emotional as well as the psychological and intellectual content of what is being communicated. Reflection includes an analysis of the group processes themselves.

In deep learning, aspects of the therapy group are integrated with the seminar. The deep learning group is more than either seminar or therapy group. It is a focused community where each member brings his or her whole self into the interactive process. Deep learning attempts to refute the accepted truism that self revelatory feedback and intellectual understandings are contradictory processes which must be carefully separated.

The primary difference between deep learning groups (hereafter called "DLGs") and encounter groups, T-groups, therapy groups, and sensitivity training groups (See Gottschalk & Davidson 1972) is that DLGs are truth-seeking communities of inquiry. They foster the maturation of members in all domains: cognitive, affectual, and ethical. Unlike encounter groups, DLGs do not pressure participants to express immediate feelings and evaluations. However, such expression is welcome and, when appropriate, encouraged. Unlike therapy groups, DLGs are not seen as "treatment" for "pathologies" or even "dysfunctions", and members are not seen as "in recovery," as "victims," or even as "survivors." Members of DLGs are co-learners. DLGs look for communicative problems, such as double binds, which make incongruent communication and consequent "schizophrenic" types of individual and social detachment so prevalent. (See M. C. Bateson, in Rieber, ed., 1989)

Presented here are examples from two small group seminars which attempted to accomplish the integration of emotional and intellectual learn-

ing. Both groups were graduate seminars in sociology at major universities. The first concentrated on the theory and practice of small groups (my seminar "Bentz"). The second dealt with sociological theory and research (The Scheff seminar). The names of participants have been changed, except for occasional references to Scheff and to me.

The Scheff Seminar on Theory and Research

Thomas Scheff integrates intellectual and emotional learning through a theory which describes how emotions relate to the quality of the social bond at any given time. Scheff (1990) contends that in every communicative interaction, persons are either damaging, enhancing, or maintaining the existing social bond. All interaction is a mixture of solidarity and alienation. Shame and pride are the two poles of social emotions. We feel pride when we feel connected to each other and shame when we feel either fused or alienated. Individuals with healthy social bonds acknowledge the boundaries of the self and of the other. Many people mistake fused emotions with intimacy. This is a pattern which today has been labeled "codependency" in the pop psychology literature. It is typical for women to be comfortable with fused emotional boundaries and for men to feel more comfortable in a state of alienation. Secure social bonds involve emotional and intellectual "leveling" which means communicating accurately what you think and feel at any given time, especially concerning your relationship with the person with whom you are communicating.

Theoretical learning, to Scheff, is necessarily tied to emotional learning. One cannot inquire with sensitivity and awareness into social, political, and philosophical issues without self-examination. To Scheff, this necessarily means examining both shame and pride, and their relationships to the emotional knots and bonds which continue from our relationships with members of our families of origin.

Scheff accomplishes the objectives of deep learning in his seminars by teaching theories of the social bond, of family of origin, and of emotional dynamics, he uses role play of scripts with members of the family of origin, and discussion of key theoretical texts. Within the group setting, a method of videotaping and analyzing the underlying emotional dynamics in the interaction is taught and promoted. Scheff calls this "discourse analysis." Unlike "conversation analysis," discourse goes beneath and beyond the words verbally expressed, to interpret the underlying emotions. Scheff eliminates the role of the professor as the group facilitator in his seminars in an attempt to mitigate against the distortions of power. He uses the tech-

nique of volunteer group facilitators who set the agenda for each session with the group.

Thomas Scheff's model for the seminar integrates both theory and practice, and involves and respects participants as whole persons. He integrates his work on self-esteem, shame/pride, solidarity and alienation, creativity, the macrosociology of war and peace, and microanalysis of discourse and family systems into his seminars. In this way, the structure of the group is not contradictory to the intent of the material—to enhance and emancipate human beings. His seminars are group "metalogues." (See Bateson, 1972, p. 1) The intellectual content—the theories, and readings in the texts become threads in the fabric that is the lifeworld of the group.

Example One: Tuning In

One way in which emotional aspects may be brought into any group process is through "tuning in." At the beginning of the group session, each member is invited to briefly describe his or her state of being. This may include current feelings, thoughts, or matters of concern. The check-in is offered freely, without pressure to disclose, but with acceptance of whatever each feels is important. It is agreed that members will not feel obliged to provide feedback. If a member wishes to comment, this is accepted. Some members speak cursorily about what is on their minds, while others bring up deep and important concerns. For example, one day "Nancy" came into the group and burst into tears. Her daughter was in the Philippines, and there had been an earthquake. Her daughter was not hurt, but the worry and stress had upset her. Her tears were accepted and her feelings supported before the group went on to other matters. By contrast, in the same check-in, another group member reported rather cursorily on his work on a term paper.

Each participant brings to the group (seminar) an emotional state—a condition—which must either be acknowledged and accepted, or repressed. Congruent communication requires that members express "where they are" emotionally and physically. As in the following example, no one blames anyone else, or offers personal criticism or attacks.

> Jack: I'm feeling pretty good. I'm getting into some areas of Mead that I like.
>
> Charles: I'm doin' pretty good. It's the end of the quarter. . . . Like Lorrie, not sure where goin', work well under pressure, got a new idea, feel pretty good about where I'm going.

Joan: I'm feeling good. I learned how to use the video camera this week, and I'm feeling a little bit anxious, because I'm going to be interviewing some students. . . . It's kind of like falling into a dark hole. I'd like some feedback about where I'm going.

Valerie: I'm O.K. I apologize for being late. I'm tired. I've been in a stressful situation all week. I've been in a kind of a fishbowl situation at a retreat which is part of a job interview. It's been going on all week starting Sunday through Friday twelve hours a day. I was looking forward to coming here only to find out I'm being videotaped. But it will be O.K., I guess.

Ray: I'm kind of tired, I was working really late last night.

Negotiating an Agenda

An important way to alleviate the power dynamics which can distort communication is through the ongoing negotiation of agendas. This includes negotiation of goals, activities, processes and amounts of time spent. Power distortion is mitigated through the changing of facilitators. Each seminar session, a different student volunteers to function as group facilitator.

The agenda is open for additions and revisions during the negotiation process, and the amount of time to be spent on each agenda item is decided upon. This does not mean that the facilitator moves the clock by an iron hand, because as things come up, the time for each item can be renegotiated, and items that do not get covered are often tabled until the next meeting. Toward the end of each session, plans for the next session are tentatively made, with each person, including the professor, given the opportunity to offer an agenda item. A volunteer is sought to be facilitator for the next session, and the tentative agenda is given to this person. Then closing comments are made by each member. Again, each person is encouraged to express his or her emotional and mental state. Others are free to offer supportive comments if they are moved to do so.

Charles: I probably sound kind of funny. Actually I'm feeling better. I'm on the down side of a cold. I'm looking forward to a vacation I've got planned for next Tuesday.

I volunteered to be facilitator. Let me just read what Joan wrote down, agenda. . . . Dr. Scheff has agreed to tell about Durkheim, and that has already been put off for a week, we talked about doing some family systems dialogues, Joan, Valerie

and Robert and I have volunteered ours, we'll have to talk about research proposals, Lorrie, Joan, Gerald and myself. I hope I'm not missing anyone. Does anyone have anything to add to that list?

Scheff: Last time I mentioned we should talk about what we would do in the next session, next week.

Jane: We need to have time for Joan to get her feedback. . .

Gerald: All right. . .Let's see. I'll reread the list then: we have Durkheim, perhaps some family systems dialogue, I could do research stuff, Joan's research, and the agenda for next week and next term. Any suggestions for where we begin? (looks at Scheff)

Scheff: Let's see, could we put the . . . family systems next to last, and start off with the research, then Durkheim, then family systems and then the future.

Gerald: We have two hours, so, we could maybe devote twenty-five minutes or so to each? Is it alright if we cut it up like that?

June: Is that long enough for Durkheim?

Scheff: (quietly) "Oh, yeah"

LAUGHTER

Closings

As with tuning or checking in, closing comments are framed in terms of one's own emotional/intellectual state at that immediate moment. No one blames anyone else, or offers personal criticism or attacks. One of the most moving closing comments in the seminar was made by T. Scheff at the end of a highly productive session. It was especially poignant because he is an internationally known scholar and author, speaking at a major university in a graduate seminar on theory and research. He spoke with his eyes diverted downward, slouched in his seat: "I feel bad. . .I feel inadequate. . .I feel like a failure." Because Scheff could level about what he was feeling at that time, each student could be free to acknowledge his or her own feelings of embarrassment, shame, failure, lack. He demonstrated one of the ways by which power figures can dilute the effects of their power—-by showing vulnerability to such feelings.

Bentz's Self-Reflective Group

This group was a graduate seminar on the theory and practice of small groups. The group met over a three month period, on three weekends once a month. On these weekends the group met on Friday evening, all day Saturday and on Sunday morning. In between meeting times, the group members reviewed tapes and notes from the group and related theoretical readings to what occurred in the group itself. The theories most discussed and applied were object relations (Dunfy, 1972), group developmental (Lacoursiere, 1980), structural functional (Mills, 1990), and group fantasy (Slater, 1966). The theories which most informed the ongoing process, but which were not read and directly applied in writing by the group members, were those of Habermas, Scheff and Satir.

On the first weekend I used the technique of open-ended choices, with myself as clear leader but with a participatory, non-threatening emotional style. The first weekend was marked by Ralph's absence on the first night, and by two sociodramas on Saturday, the first representing Roger's multiple internal selves, each played by a different person, each representing a different attitude toward the recent declaration of war against Iraq by President Bush. The second sociodrama represented Kathy and her husband in several scenes involving conflict. Larry continually left the room, and asked for a break. He seemed uncomfortable throughout this first session.

Group members viewed videotapes of the first weekend, and related what had actually happened to theoretical frameworks. After a month's absence, the second weekend began with an attempt to disperse the role of the facilitator among different group members, using T. Scheff's model. Ralph, the most domineering male in the group, volunteered to be the first facilitator, setting the stage for conflict between those who wanted a traditional structure and those who wanted to continue to explore a less structured approach. One extreme was supported by Roger, whose ideal was a "leaderless group," where each person would be responsible for leveling. Saturday afternoon, Gladis, an extremely nondirective leader, took over the role of group facilitator. Most of her facilitation centered on trying to decide what to do. Sunday morning I took over leadership again and began with an exercise in "leveling" with the group sitting on the floor in a circle, touching feet and holding hands or with their arms around each other. The session ended with intensive critical feedback between members and the recognition that the group had finally opened itself up to true leveling. This occurred after I confronted them with a Langsian interpretation of a discussion of rape and fear of rape which Nancy had brought up following the time on the floor. (The Langsian interpretation involved the suggestion

that they felt violated by the physical contact in the group and threatened by the fantasies and suggestions brought up by the exercise).

The third session continued the leveling in a less conflictual and more relaxed manner. The group had been through its crisis, and now entered a phase of high productivity. Kathy had emerged as a group scapegoat, and Barbara did not return. Gladis, Nancy, and Rhonda represented a clear "feminist coalition," Ralph and Larry masculine tradition, and Roger and Joyce the voices of knowledge, skill, and reason, with Cordelia supportive all around.

Saturday morning began with Joyce presenting a problem which she wanted to have the group present and analyze in the form of a sociodrama. The problem concerned her relationship with a male friend, with whom she had lived for several years. This friend was unable to continue the friendship because she had a serious boyfriend. Her friend was jealous of the sexual relationship she had with her boyfriend. He had agreed to a "friendship only" relationship with her, but had changed his mind about it. She consequently felt betrayed. In the role play, Roger played the friend and I played Joyce. The dramatization was followed by a discussion of sexuality and intimacy, and male and female feelings along these lines. Following this emotionally involved discussion, Ralph once again brought up his need to feel that we adequately cover the theoretical content of the course. I agreed to present a brief lecture after lunch in which I would overview the field of small groups theory and research, distinguishing between sociological research approaches and psychological research approaches. I found giving the lecture personally alienating, and because of this my anger came through as I lectured. A student remarked that she was afraid to sit close to me at that point. Once again the group had turned to discussions of intimacy, sex roles, and sexuality.

Transcript: Langsian Interpretation of Derivatives

> Valerie: What is it in the group which brings the discussion back to issues of sexuality, intimacy, relationships not going the way they should, betrayal. . . . What is the derivative (in the Langsian sense) interpretation of why we did that particular sociodrama this morning? (Joyce's problem with maintaining her Platonic friendship with a male.)
>
> Gladis: I think it has to do with the clash between two different factions who want intellectual and who want emotional stuff to go on. . . . these have sexual connotations, perhaps the theory people are uncomfortable with emotions. . . .

Kathy: I think we're exploring group intimacy, we're trying to evaluate intimacy within the group, and that's . . .

Joyce: We're also finding out what intimacy is within this group, we're finding out what it will mean for us . . .

Roger: It's more of a I think it's very unfamiliar to be authentic and talk about what's going on in a group like we were this morning. As so it's like my natural tendency's to drift away from that. . .for me it rings true that it takes a lot of effort and energy to be that present with other people. It was sort of along gender lines. . . .

Gladis: I would like to ask Valerie about female theorists. Every theorist we read about here was male. . . . I read where there are female processes and male processing is different. . . .

(Here follows a discussion of male and female theorists, intimacy, and the energy required to be emotionally present.)

Intellectual Learning in Context of Emotional Understanding

The above example is, itself, an intellectual discussion about intellectual and emotional understanding.[3] The following segment shows integration of emotional and intellectual learning through the group members' interpretation of their own processes. I selected this particular segment to transcribe because it shows how concepts or theories are brought into the discussion spontaneously, as the need arises.

The session continues with are several requests for information or analysis. Gladis requests female theorists (directed at Valerie). She requests an explanation from Joyce of Martin Buber's concepts of I-Thou Relationships. Nancy inquires about power and her motivation for feeling in conflict with Ralph. Then Nancy brings up her conflicted feelings about intimacy in the group and the group's termination. Joyce offers emotional support for dealing with the termination of the group by presenting Buber's viewpoint on the value of I-You relationships. Here emotional reassurance is exemplified in the form of the intellectual comments.

As this transcript continues, it moves into a theoretical explication which emerged from the concerns of the group. The discussion of theory arose from the grass roots of the process itself:

Joyce: I wonder if it's possible to do that over the whole day. I think of Martin Buber's I-Thou, I-You relationship this morning. He says we cannot sustain it long. The demands of everyday life. . .

Gladis: I wonder if you could explain Buber. I've heard his name (looks at Joyce)

Joyce: Buber makes a distinction between the I-dash-You relationship and the I-dash-It relationship. In the I-dash-It relationship usually it is descriptive, purposive, immediate. Where as the I-You relationship is hard to describe it is not object oriented but being in itself, it is not a set of characteristics, it is a whole. It is impossible to be in it all the time. He says that to live [43.29] authentically we must be open to I-You relationships. You can't make it happen, it flows you are open to it happening, it's never sustained. This morning we had an I-You relationship, we were leveling, being real with each other . . . .

The rest of the discussion is about the relationship between I-you communication, gender, power, intimacy, and boundaries. Following this by a student brings up the subject of the impending end of the group and her feelings of grief. Several students and I cried during this segment.

Example: Family Systems Dialogue

In the Scheff seminar, the most poignant example of intellectual/emotional learning was a role play of a group member's conversation with his mother. In the process, Robert leveled with his mother about the way he felt when she made a critical comment about his shirt. He went down to a deep feeling level, and commented about his feelings as he experienced them. Precisely at that moment, he learned about an unacknowledged feeling dynamic between himself and his mother. Those present learned not only "about" family systems and sociology of emotions, but also how emotions can be deeply understood. Robert demonstrated—embodied—a principle which Scheff had stated on a previous occasion in the group. "To become a good sociological researcher you must first of all become a researcher of your own family system." Robert presented his dialogue in the form of role play with "Joan," playing his mother.

Robert: O.K. this is um my mother at "Did you put on that shirt today. Did you put on that shirt today?"

Ahm I say "Yes Mom, com'on we've got to go pick up Judy."

My mom is a bit incredulous, there's surprise in her voice. "Did you put on that shirt today? Yes Mom, we've got to go pick up Judy. "

Its a commentary on the state on the condition my shirt is in. She's making a comment on my shirt. It looks like I slept in it she's saying.

Joan: Oh.

Group: laughter

Robert: and I don't respond to that until twenty-four hours later. I have a little fit of anger. . . .

Valerie: Was that pretty typical, your mother asking you about the shirt and your? . . . .

Robert: Un hum. . .

Scheff: O.K. The dynamic way to deal with this here is to have the coach give Robert counterfactuals. . . . What we are looking for here is . . . emotional discovery. The reason that we are all stuck in our family system is that we are avoiding occluded emotions. The point of doing the role taking is to find those feelings.

Joan: O.K. Lets look at the mother son Uh, What would a counter factual to this be, to your mother. O.K. she could say, "Did you put on that shirt today?"

Robert: "What do you mean mom." Go ahead.

Joan: You, it kind of looks kind of like wrinkled and kind of inappropriate.

Robert: Hum! I can feel the anger welling up . . . [laughs]

Robert: I'm ready to like blow your head off He He [laughs]

Group: [laughs]

Joan: You always wear shirts like that.

Robert: Ha Ha

Group: laughter

Robert: Eah Ah. I'm not going to say mom what you always do. He he he. This is real liberating for me to laugh about this, you know, and it is real hard for me to think of a constructive response cause I can think of a thousand ways of really [hits his fist into the palm of his other hand twice, audibly] getting into it. . . . Say that to me again what you just said.

Joan: You always wear shirts like that. . . .

Robert: Ha He. . . I tell you what mom. I feel real cut off from you right now. I feel real cut off from you right now.

Joan: I don't understand what you are talking about.

Valerie: Do you want her to be like your mother with you?

Robert: No, she doesn't have to be like my mother. She's just trying to get me to feel things, any which way, no matter

what. . . .

Joan: Um, I don't understand what you are talking about.

Robert: Gee that really makes me mad. He He!

Robert: You know I just feel like hitting and scratching and biting. . . . Well, want me to try to explain?

Joan: Yeah, Why don't you try to explain, this is your problem.

Robert: Yeah, now I feel like crying, you see. [Looks down. Looks like he is going to cry.] Say it again.

Joan: Just like that?

Robert: Uh, that would be great.

Joan: Yeah, why don't you tell me what it is that you feel.

Robert: You sure you want to do this? [laughs heartily]

Joan: Yeah.

Robert: O God. I feel real hurt. Like infinitely hurt. That's how I feel.

Joan: I'm sorry you feel hurt.

Robert: That doesn't help a lot.

Joan: I'm glad you told me you feel hurt.

Robert: That helps. [nods at her]

Joan: You know, you and I need to level about this.

Robert: We've never done this before.

Joan: You want to level now?

Robert: Be receptive.

Joan: Well, I'm kind of scared of talking about these things.

Robert: Yeah, me too.

Joan: I'm pretty scared.

Robert: Let's be scared together then.

Robert: See that would be closer than I ever got to my mom, that, right there. . . . Now, I'm feeling a lot of feelings right now, I'm all a tremble. (He is visibly shaking.) Uh huh. We. . ., so far this is a big success, Mom, you're doing real good.

Joan: So are you, I really appreciate your telling me.

Robert: Ah, I like to be real direct, and I want to be able to tell you like I'm hurt or angry. Is that all right?

Joan: I would really appreciate that.

Robert: O.K. I feel real blocked right now and my feelings are going away. . . . Now it's coming back, the feelings. I'm real baffled, Mom, and stuck. Is it all right for me to tell you that?

Joan: Yes.

Robert: Are you sure?

Joan: Uh hm.

Robert: Because I feel like I have to be perfect. [Voice quivers, is about to cry.

Joan: You don't have to be perfect.

Robert: Let me hear that again.

Joan: You don't have to be perfect.

Robert: That's a relief [he he he] Oh I can't tell you what a relief that is. Say that one more time.

Joan: You don't have to be perfect. You're perfect just the way you are.

Robert: No, I don't want to hear that. He He. I don't have to be perfect.

Joan: You don't have to be perfect.

Robert: That's real hard for me to hear from you. Cause I felt [throat catches, like [crying] I've always felt that's what you want—a perfect kid. . . And I can't do it. I cannot do it, I cannot do it. [each time louder, like through crying] can't do it. Can you hear that?

Joan: Yeah. You don't have to be that any more.

Robert: I can't stay in this, I can feel myself clicking in and out. It's a real hard. . . .O.K. That's the end, kind of thing, I feel like something happened. . . . I took about as much of those feeling as I'm capable of taking at this time.

Joan: Is there anything I can do, being your mother, that would feel really good to you?

Robert: Well, everything you said felt really good. Like I took deep dives, like a relief, like I was doing that for so long.

Joan: Did you ever hear her say that she loved you?

Robert: [nods]

Joan: So you weren't waiting for that.

Robert: No.

Joan: I just thought I'd check that.

John: What happened to the anger?

Robert: I have the feeling that's not the issue. I have gotten angry. . . . Broke dishes, etc. I just felt guilty. . . But this stuff got right to the core. If I could cry for a couple weeks I'd feel better.

Conclusions

Deep learning is a communicative process whereby profound truths are realized. These truths are realized emotionally and intellectually. They are socially created in a small group atmosphere of trust. They may begin with a quest for intellectual understanding consciously open to its feeling components, which are then brought forward and fully expressed (Scheff group). Or they may begin with expression of feelings which culminate in profound intellectual questions with explorations of theoretical explanations (Bentz group). When such shared moments are achieved, members feel renewed. Such moments structurally change the participants.

Deep learning stimulates the maturation of the members through communication processes which promote congruency between emotional and intellectual expressions and allow for catharsis and insight. Crying and laughter are part of the process, as recognitions of ironies and as releases of blocked emotions. Deep learning groups facilitate reintegration of messages from the body and the emotions with intellectual insight. The participants feel calm and energized, peaceful and excited, full of achieved insights and new questions.

NOTES

1. I am indebted to the students in my seminars, especially during the fall and spring terms 1989-1990, and to the students in Thomas Scheff's seminars, spring 1990. I am grateful to Tom Scheff for opening up his seminar to me, and to Rich Applebaum and Don Zimmerman, Chairs of Sociology at the University of California at Santa Barbara, and Joyce Williams, Chair of Sociology at Texas Woman's University, who were supportive of my time as Research Sociologist at UCSB. I greatly appreciate Philip Mayes' encouragement, thoughtful critique, and assistance. Only I am responsible for the content of this article.

2. Stolorow and Atwood (1979) attempt to perfect psychological theory through an analysis of the effects of unfinished issues from the childhood of the theorists and of certain historical factors on their ideas. This is a critical hermeneutics of written discourse which parallels Habermas' "ideal speech situation."

3. During this segment there were no cathartic displays of emotions (crying, laughter) Voices are consistently soft, speech pace is moderate to slow. There were no tense pauses in the speech, no aggressive interruptions, little overlapping speech. There was only one clear "shame" gesture, made by Kathy who hid her face with her hand, from the camera, while talking of common needs for intimacy.

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Using Sociology to End Chemical Dependency

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ABSTRACT

Drawing on participant observations and interventions while counseling 160 heroin addicts over a two-year period, the author explores the possibilities and limitations of using sociology to counter his clients' addictions to heroin and other drugs. Important historical changes have brought about new conflicting viewpoints within the methadone maintenance clinic, where acupuncture and Chinese herbal treatments are now available alongside Western medicine Although sociologists have written harsh accounts of "getting the treatment," they have tended to support methadone maintenance, which has been demonstrated to stem crime and HIV, among other socially beneficial ends. Clinical sociologists can resocialize addicts to mentally-healthful social solidarities, demystify the socially destructive effects of drugs, and criticize ineffective, dehumanizing treatment techniques and ideologies

When a counselor sits down with a client who is a heroin addict attempting to heal or to cope with addiction, a sociologist would identify these two people as taking part in a definable status-role relationship. Specifically, the status of a counselor is attached to the roles of active listener, monitor

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of randomly taken urinalysis tests, supportive inquirer into a person's history and current well-being, compiler of legal files pertinent to the client's program compliance, and challenger of irrational thoughts, reasoning, and actions which contribute to the person's addiction. In comparison, the status of a person under treatment in a methadone-maintenance clinic is assigned to the role of a client who must follow the rules of the methadone-maintenance program—the very admission to which is frequently required by an agent of formal social control, such as a parole officer, or by the client's own desire to cope with or end his or her addiction to heroin and other drugs. Thus, the client is frequently defined by society as a criminal, either because the client has been apprehended for a felony or misdemeanor, such as burglary, related to supporting his or her addiction, or because society has defined dependence on extremely addictive substances as a serious offense. In brief, from the earliest studies of addiction, sociologists have frequently pointed to the Harrison Act as a major factor in creating what is identified as the pattern of normatively disapppoved behavior associated with addiction to heroin, morphine, and other opiates. They argue that by preventing legal access to these drugs, the Harrison Act and other related legislation drove up the price of these substances and forced their production, distribution, and exchange into the market of organized crime (Clausen, 1976, pp. 140-78, especially pp. 168-70; Duster, 1970).

In the current debate over the war on drugs, we see an unusual alignment of camps, where rightwingers, liberals, conservatives, and leftwingers find themselves in political agreement with their ideological opposites on the question of the regulation of drugs. One side favors stronger regulation; the other legalization of drugs. Both positions claim that their policies would do away with the worst effects of drugs on society. A progressive point of view falling between the two extremes of legalization or repression of drugs, is decriminalization of drugs, and this position appears to be gaining ground (Eisenberg, 1991).

From Emile Durkheim (1967), sociologists have learned that a society's laws reflect its deepest moral judgments. In a highly complex society such as our own, these laws are meticulously encoded in writing on the printed page, and now are even stored and processed electronically, while still reflecting the organic solidarity which they express. The U.S. Federal Government, through the Department of Health, Education, and Welfare's Food and Drug Administration, formulated guidelines for the regulation of methadone use in the early 1970s. Joel Martin Shteir observes that these regulations increased the control of the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs over all methadone programs (1975, pp. 34-35). In California, the most populous state in the nation, with its 30 million inhabi-

tants, society's judgments about drug use are expressed in Title 9, California Code of Regulations, (Anonymous (a), 1983), and its norms regarding methadone treatment programs in particular are encoded in the regulations in Subchapter 4 beginning on page 786.4. Every activity surrounding this opiate is minutely outlined. Such detail signifies the danger which society has ascribed to this drug and its impact on its well-being. Some investigators have claimed that the degree of social mobilization against drugs at various times in American history can only be understood by putting these social movements into the context of society's emphasis on the Puritan values of hard work, sobriety, and the acquisition of material goods in this world as a sign of salvation in the world-to-come, and thus to an extreme devaluation of substances which deflect human action away from such values (Larner, 1991; Massing, 1991).

There are several levels at which sociologists have applied their skills in the area of substance abuse. At the most prestigious and well-paid level, a handful of sociologists have acquired very large grants to study the patterns of drug intervention on a national scale (Biernacki, 1986; Feldman, 1973; Robins, 1985). Others have obtained smaller training grants for study of a particular research question, for a limited amount of time (Coombs, Fry, & Lewis, 1976). Still others have specialized in descriptive qualitative studies of the quickly changing drug subculture (Becker, 1963; Lidz & Walker, 1980; Rosenbaum, 1981; Stoddart, 1991), or have applied methodologies to analyze drug-related data (Gurdin & Jeremy, 1987; Gurdin & Patterson, 1987; Guttman, 1982; Levy, 1989) or psycho-social interventions (Watts, 1988).

In this essay, I have drawn on the works of several sociologists as applied to the issue of counseling drug-dependent individuals. Particularly helpful were Robert Sévigny's publications which applied Carl Rogers's psychological insights to a variety of fields of sociological research (Sévigny & Rhéaume, 1988a, 1988b), and Hans Peter Dreitzel's (1977) critical sociology of roles. In the clinics where I have worked, the chief clinical psychologist has been inspired by the work of Albert Ellis, and has encouraged counselors to employ Rational Emotive Therapy, which shares many common assumptions with cognitive sociology (Ellis, McInerney, DiGiuseppe, & Yeager, 1988).

The Social Context in Which Sociology was Used to End the Chemical Dependencies of Clients

When I speak of having used sociology to end the chemical dependency of clients, let me emphasize that I have drawn on sociology within a particular, institutionalized context which has imposed extreme constraints on

its use (Fagan, 1991). The context is that of methadone maintenance clinics in the Bay Area. All counselors in the two clinics in which I have worked are required to meet a caseload of forty clients at least twice a month, for a minimum of fifteen minutes per session, and to write up casenotes on each of these meetings. Most of my sessions last considerably longer, on the average between 30 and 120 minutes per session, depending on the client. The clinic cares for approximately five hundred clients, and has detoxification ("detox") and maintenance divisions. When the random urinalysis results are available on a listing, they are recorded in the chart by the counselor, who must ask the client for a response if the test result reveals the presence of any substance other than methadone and methadone metabolite.

After the counselors have done an initial clinical assessment—which is basically an extensive life history, focusing on the client's drug use—they compose an initial treatment plan (TP), which is divided up into three areas: the identification of a problem; defining goals for change associated with the problem; and specifying means of action into which these goals are concretized. These treatment plans are sectioned into nine content areas, of which only a few are actually spelled out in any individual's TP. The State of California requires the counselors to revise these treatment plans every quarter. The nine content areas are as follows: 1) drug use; 2) medical; 3) legal; 4) psychosocial; 5) educational/vocational; 6) program compliance; 7) housing; 8) financial; and 9) AIDS education. A problem, goal and action step statement corresponds to each of these content areas. In addition, the frequency of counseling, the contract types and durations, the urinalysis results during the last three months, methadone dosage, current take-home status, the client's name and I.D., his or her start date, an effective date, and the client's, counselor's, physician's and reviewer's signatures must be recorded within a rigidly specified length of time. At a later date, a supervisor or chart reviewer may make comments during a review which must be formally replied to by the counselor. The rigidity of these requirements means that a great deal of time must be spent on clerical details before the actual counseling process may even begin.

In the context of the methadone clinic, the counselor promotes a process of change away from the use of illicit drugs, primarily by exerting social control by means of the introduction of informational change at the individual and group level (Grawitz, 1972, pp. 855-890). By introducing new information, which frequently contradicts old information, the counselor promotes changes in thoughts (cognitions) and feelings (emotions) about drugs.

By the time a heroin addict has enrolled in a methadone maintenance program, she or he has often begun to employ the addiction to heroin and/or other substances and a role based upon this addiction as a means of defense, attack, or adjustment to the overt and covert problems created by the consequent societal reaction to the addict. Edwin M. Lemert identifies such deviation as secondary (1981, p. 196), and Jeanette Covington's Ph.D. thesis (1979) is particularly relevant to this process for chemically-dependent clients. The task of the clinical sociologist is to record the complicated process by which a client's deviation has become secondary and to reverse those attitudes, beliefs, and overtly illegal acts which result in extremely punitive societal reaction to the client, while providing emotional support to the client as a person who is worthy of others' care and affection. The DSM-III-R psychosocial stressors discussed in the paragraphs below provide a convenient checklist of life areas where primary deviance often evolves into secondary deviance.

I frequently use two exercises to help clients to understand where their drug use has led them and to help them realize that it is possible for them to break free of their dependence on heroin and other illicit drugs. In the first of these exercises the client is asked to compile a list of the ten worst things heroin has done to them. After discussing this list—which frequently reveals the client's path to secondary deviance—I ask the client to carry the list with them at all times and to read it and reflect on it whenever they have a craving to use drugs. They frequently acknowledge that such acts as stealing from family or physically or verbally abusing friends or employers—influenced by the highs and lows of their drug use—are unacceptable behavior—even when such acts are a response to others who have harmed them. They may want to apologize or offer amends to those they have hurt. A second exercise I often incorporate into my clients' treatment plans urges them to draw a picture of themselves as a "dope fiend" and another of themselves as a "drug-free person." Frequently these sketches depict an unhappy, unhealthy, lonely drug user and a happier, healthier, more sociable drug-free individual. These drawings are useful to combat the false belief—"once an addict, always an addict"—that may undermine the efforts of long-time users to end their drug dependence. To counter this same false belief among my more highly-educated clients, I ask them to read and discuss Patrick Biernacki's (1986) book, or I refer them to Marsha Rosenbaum's work (1988).

As a clinical sociologist, my treatment plans frequently identify DSM-III-R psychosocial stressors, considered along Axis IV, which need to be changed if drug use is to stop. Employing these DSM-III-R stressors avoids the problem of "the physical and emotional dimensions of human experi-

ence" which Hans Peter Dreitzel finds lacking in Jürgen Habermas's "theory of the evolution of human competence" (1979, p. 117). The first such stressor is conjugal. Not infrequently, a partner of one of my clients ends up incarcerated—leaving my client to deal with this separation. This may sometimes be a good point at which to reevaluate the relationship. Here it is necessary to decide whether the client's relationship contributed to, is neutral toward, or helped to end his or her drug use.

Developmental stressors in my client's life may include such factors as Late Luteal Phase Dysphoric Disorder (DSM-III-R) or a teenager at home whose drug use is driving my client to decompensate. Here it should be noted that my sociological knowledge is not accessed independently of my knowledge of the psychology or biology of addiction. For example, the psychological observation that addicts have a low frustration tolerance may lead me to expect that a female client who is a heroin addict may experience a higher level of pain during Late Luteal Phase Dysphoric Disorder than a non-addict. A family session in which poor nutrition is revealed may suggest that dietary change may be an area where the counselor may refer a client to books, nutritionists, or other resources in order to decrease the severity of this kind of stressor. For example, sugar is often found to be a large part of my clientele's diet. When this is the case, I refer my clients to a book written by medical doctors (Phelps & Nourse, 1986) or a popular nutritionist (Lappé, 1982). If the client is a poor reader, I verbally summarize this information for them and monitor their change in diet.

In the area of family stress, it is sometimes necessary to request that clients set limits on family members who cause physical danger or harm to the family system. Thus, when one of my clients would not permit her crack-addicted teenager to enter her home until this person entered treatment for or ended his addiction, calmer bodily cues from the client and her young children were immediately noticeable. Moreover, as long as this constraint was upheld, her urinalysis results remained free of illicit opiates.

Most of my clients live under constant financial stress. To a client of mine who was homeless until taken off the streets by a crack dealer, it was not apparent that the crack dealer was using him as a customer and that his addiction to crack cocaine was the major cause of his homelessness until this counselor suggested it to him. Often clients must be reminded that if they had not spent $125 on a gram of heroin in one day, they would have had $87.50 to pay two weeks of fees for their methadone clinic, and additional money to pay rent, purchase clothes for themselves, and their families, and eat on a regular basis.

My clients often also have legal stressors which constrain their freedom. By referring them to free or moderately-priced legal aid, or by writing,

speaking or meeting with their parole officers or lawyers, I have been able to help, for example, a client end a debt to a dead person for which he was still being pursued by the law.

By taking my clients' occupational stressors, particularly unemployment, seriously, I frequently met the opposition of other counselors trained in marriage and family counseling or psychiatry (see also Lidz & Walker, 1980). These colleagues frequently argued that the client was not ready to go back to work and that coming to terms with their addiction was the client's primary job while in recovery. I do not dispute that recovery is hard work or that dysfunctional action influenced by addictions may impair or impede job performance. However, as a sociologist, I am particularly sensitized to the importance of work in imparting meaning, structure, identity, and some measure of economic security to an individual. Many of my clients hold down jobs performing essential work for our society, from building buildings to providing legal and other professional services. The socio-economic class demographics of my clients has been similar to the breakdown of Patrick Biernacki's interviewees (1986, p. 173).

I have attempted to draw upon other interpersonal stressors to focus my clients on the impact of these stressors in the ongoing meaning of their lives. One of my current clients lost a friend to lung cancer. Like my client, this person had smoked tobacco cigarettes. Before the death of his friend at a relatively young age, my client had never considered giving up smoking, nor the relationship of his recovery from heroin addiction to his addiction to smoking tobacco. By providing information on the health risks of smoking tobacco and by pointing out an older client at the clinic who has a severe case of emphysema, my client was persuaded to consider joining a smoking cessation group.

Other psychological stressors that frequently arise are death and rape. Some of my clients have lost many friends and intimates to HIV. One of these clients recently noticed several bodily indicators that made him think he had the disease. Despite months of trying to persuade this individual of the advantages of early detection and intervention through periodic testing, he resisted being tested for HIV. When he finally was tested, he was certain that the results would be positive, and began to plan his own demise. I emphasized the irrationality of jumping to conclusions before he had the results of the test, the need to be retested to confirm the results whatever they might be, and the many changes that this individual and his partner could make to live prolonged, higher quality lives. When it turned out that this person and his partner both tested negatively, despite his foreboding, I tried to use this "new lease on life" (to use his terminology) to exhort the

client and his partner to make changes to ensure the client's freedom from illict substances and to promote their greater well-being.

The stressor of parenting frequently exerts influence on a client to use illicit substances. One of my clients who more than a year previously had been placed on a contract to never again tamper with his urinalysis test, came up with a second incident of this nature. This client's wife, who was addicted to crack cocaine, had just returned to his apartment after many years' absence and left their two children with my client, after stealing one of his few valuable possessions. At the same time, this client discovered that he needed to begin treatment for a serious disease. After becoming primary childcare provider for his children, this client, who had been clean of illicit drugs, suddenly began to come up "dirty" for these substances. At this clinic, the director interprets contracts dealing with tampering literally, and such an incident leads to the termination of the client, subsequent to a thirty day period of gradual detoxification from methadone. Although I pleaded that this individual suffers from short term memory loss, he will most likely be terminated. In attempting to make the best out of the situation, I have tried to persuade this individual to get on another treatment program.

Social control of clients by their counselors is accomplished through a counselor's verbal and non-verbal communication of approval or disapproval, or more formally through the mechanism of written contracts. For example, this counselor recently led a small group discussion about the negative impacts of drugs on community life. All of the participants reported and acknowledged that life in their neighborhoods had become more dangerous; shootings, stabbings, woundings, stealing, and murders had increased tremendously. Denizens of neighborhoods had begun to lock and bolt down their houses, cars, and all possessions more frequently than when there were fewer drugs. Trust in one's neighbors had declined precipitously. Yet, many of these same participants tacitly or explicitly confided that they had engaged in similar activities which undermined the quality of community life. When challenged to explain their belief that they had to sell drugs to get any satisfaction out of life, these clients retorted that if they did not sell drugs then someone else in or outside their communities would make the large profits to be made in the selling of drugs. While acknowledging that the clients might be correct in this matter in an immediate, superficial sense, I stressed that they were actively and unnecessarily making their own lives more unpleasant, dangerous, dysfunctional, and unhappy, when there were alternative methods for these clients to improve themselves and their communities in many different ways. I emphasized that by getting together in community organizations they could come to build trust with their neighbors around specific isssues such as pre-

serving their current level of funding in public education and community services such as park and recreation activities. Yet, in one group I was unsuccessful in persuading my clients that they would be safer if their communities were rid of handguns, AK-47s, and Uzis or if the police were able to effectively control the trade in guns and highly addictive substances. In contrast, however, limited to the verification of a client's self-report, I was successful in convincing one client that Child Custody and Protective Services would be less likely to take his beloved child if he were to dispose of or put under lock and key all of his plentiful firearms and keep them out of the child's reach. Furthermore, after citing statistics on domestic violence, I convinced this man, who was a graduate of one of America's top prisons, it would be less likely that he himself would be injured or killed during his partner's unpredictable alcoholic binges, and would be under less suspicion by the law, if he had no accessible weapons.

As an example of how these stressors relate to the unlearning of secondary deviance, I refer to one of my clients who appeared in the national media in September 1991. This client is a successful young writer who recently published an article in a national magazine about tracking down the molester of his son, and how this experience helped him become conscious again about having been sexually coerced by his own father for a number of years (Anonymous 1991, pp. 46-51, 60-61). The client and I agreed that dealing with this fact is an important factor underlying his addiction and have incorporated it into his treatment plan. Unlearning this aspect of his primary deviance has led the client to carefully recollect all the specifics of this experience and to crossvalidate his memories with those of other close family members. It is this counselor's judgment that the client's reluctance to file the necessary child abuse charges against his own father—who is no longer in the proximity of other children—expresses itself in a great stress expressed in his very constricted body language. Yet the client must also learn to avoid covering up his emotions with drugs, which means permitting him to cry and express other feelings in our sessions as well as employing cognitive strategies to discourage the use of drugs. This client is learning to use regular meditation to avoid letting stress take hold of him. Another important way in which the client is attempting to unlearn secondary deviance is by articulating the conflicting messages his most significant other, his wife, is sending him about his career. On the one hand, she has allowed him to be absent a great deal for his writing assignments in dangerous areas and has been tolerant of a fluctuating income. Yet at the same time, she would like him to be near his family in a relatively secure environment and to provide a regular, middle-class income. Finally, we are examining in detail how the client cognitively and emotionally frames the

urge to use drugs, and are promoting replacement of the old thoughts and feelings with new, consciously positive ones. This client uses drugs compulsively by giving into boredom and fatigue at the end of a hard day's work of writing. By asking the client to identify a physical activity which he enjoys, this counselor has encouraged him to engage in this physical activity at this time of day, no matter what his other thoughts and urges might be. These techniques have been identified as the inception of cure and the beginning of the addict's "self-in-transition" (Ray, 1976).

To summarize, within the methadone clinic, a clinical sociologist working as a counselor is constrained by legally- and clinically-defined limits of the setting to draw on sociology at the microsociological level of the individual and small group and only within the framework of specifically-defined time limits and charting. Even within these narrow limitations, the application of sociological knowledge can be predicted to generate conflict with other counselors trained as psychologists, marriage, family, and child counselors (MFCCs), or psychiatrists because collective attributes are frequently denied or understood as obstacles to overcome individually. Moreover, at some clinics, trying to get clients to engage in social solidarities other than religious or quasi-religious group affiliations (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, or Marijuana Anonymous) may be labelled inappropriate professional behavior, while at others, Rational Recovery (RR) groups are actively promoted.

Conflicting Groups within the Methadone Maintenance Clinic

Joel Martin Shteir in his Master of Arts thesis presented to the Faculty of the Department of Sociology at Brooklyn College, found that there are contradictory roles of rehabilitation and social control in methadone clinics (1975, p.35). Following Joel Martin Shteir, Charles W. Lidz and Andrew L. Walker revealed a similar dichotomy when they referred to the medical and outlaw models of the Narcotics Addiction Unit (N.A.U.) (Lidz & Walker, 1980, p. 196). Moreover, one of Shteir's central findings—based on his qualitative observation of Beth Israel's Methadone Maintenance Program clinics—was that "having a professional self-image does appear to be a critical factor in role conflict. Individuals with a professional self-image generally express negative feelings against the one organizational manifestation which best represents the organization's expectations for the respondents, the rules and regulations" (Shteir, 1975, pp.73-74).

Since Joel Martin Shteir made his qualitative observations in New York State in the early 1970s, America and the world have changed dramatically

as have their drug scenes. And, of course, New York's and California's subcultures differed then as they do now. Let me briefly summarize what I see as the structural similarities and differences between Shteir's description of methadone treatment and what I have observed. Firstly, Shteir observed that counselors with a more articulated professional self-image generally felt frustrated in enforcing the methadone organization's rules because they felt it worked against the rehabilitation of their clients. To a large extent, the more highly-educated people had a more professional identity and the less well-educated appealed to a strict construction of the federal regulations. I observed a similar opposition in the clinic where I worked for the longest period of time; however, the ABDs of Shteir's thesis have roughly been replaced by Ph.D.s, marriage, family, and child counselors (MFCCs), family nurse practitioners, and foreign-born MDs, and the less highly-educated by former addicts and non-addicts with M.A.s, or B.A.s.

Secondly, regarding treatment issues, there is a tendency for the more professional to express their case interpretations and recommendations for interventions in more abstract perspectives based in biology, psychology, or the social sciences. However, since Shteir wrote his thesis, codependency theory has exerted considerable influence on work in rehabilitation, and, in my observations, the less professional practitioners have subscribed either explicitly or implicitly to more of the core beliefs of codependency theory than have the more highly-educated professionals. In the next section, I will discuss the development of a critical sociology of codependency theory.

Thirdly, the position of the social sciences has significantly weakened within American mental health practice, despite the American Sociological Association's attempt to deny the *New York Times's* story of "Sociology's Long Decade in the Wilderness" (Berger, 1989).

Toward a Critical Sociology of Ending Clients' Chemical Dependency or Against the Explicit or Implicit Application of Unconditional Negative Regard.

It is not surprising, given the weakened position of sociology and other social sciences since the advent of Reaganism, that two new books by psychologists attacking codependency theory draw heavily on social scientific works (see Katz & Liu, 1991; Peele & Brodsky, 1991). Elizabeth Paeth, M.D., M.P.H., (1988, p. 11) notes that "some definitions of codependency are varied, some very narrow and specific, others quite broad and all inclusive." Quoting Timmen Cermak, she records, "Codependence is a recognizable pattern of personality traits, predictably found within most members

of chemically dependent families which are capable of creating sufficient dysfunction to warrant the diagnosis of Mixed Personality Disorder as outlined in DSMIII" (Paeth, 1988). In contrast to Cermak's specificity, she reviews Sharon Weyscheider-Cruse's definition, "An addiction to another person or persons and their problems, or to a relationship and its problems." Lillian L. Hyatt, M.S.W., (1986, p.85) defines codependency in the following manner: "This term is often applied to any adult who assists in maintaining the social economic equilibrium (for functioning) of any chemically dependent person." A more in-depth analysis of the published usages of codependency has led me to conclude that it directly opposes the most sacred helping actions enjoined by the major ethical and religious traditions of our society.

While Hyatt (1986) and Paeth (1988) may indeed point to kinds of action that need to be changed and resocialized, in observing practitioners utilizing the concept of codependency, I repeatedly watched them refer to this concept to righteously defend their attitude of "Unconditional Negative Regard." By this rubric I reference the clinic director's revelation to me that she could never again counsel these chemically-dependent clients who, she assumes, regularly manipulate, lie, cheat, steal, and physically abuse themselves and others. When challenged with evidence that contradicted her judgment based on this assumption regarding one specific case, her response was, "I don't care what you feel!" A similarly harsh account of social interaction in a methadone maintenance program is offered by Marsha Rosenbaum (1988), Charles W. Lidz and Andrew L. Walker (1980), and Vincent Dole and Marie Nyswander (1976) before the promotion and encodification of such action as a moral good in codependency theory.

"Unconditional negative regard" also points to the irregularity and partiality with which coercive action is undertaken at clinics such as the first one in which I worked. There, the tone set by the clinical director recalled the most totalitarian features of mental health settings depicted by Goffman (1961) and Kesey (1962). Yet such coercive action, from contracts limiting a client's right to be verbally loud or profane in a counselor's office or in the clinic to the ultimate weapon of being terminated from the program—meaning an immediate or short detoxification from methadone—was usually justified in terms of the mentally-healing aspects of setting clear limits and letting a client learn of the inappropriateness of his or her behavior through negative consequences, or by the supervising counselor's desire not to be codependent. When, in case conferences, recent evidence and arguments supporting the expression of anger were presented, they were authoritarianly dismissed without rebuttal being permitted. Michael Lerner recorded, "...once that anger was experienced in a safe context, it did not

get out of hand ... As the anger gets externalized and the self-blaming decreases, the use of various narcotics to deaden pain is less necessary" (1986, p. 162). Yet, this counselor was instructed not to offer such evidence at case conferences.

In this clinic, when counselors spent considerably longer lengths of time with clients than the minimally-required fifteen minutes twice a month, they were labelled as codependent by the clinical supervisor, despite evidence that clients needed and desired longer sessions and profitted from them. In contrast, in the second clinic observed, codependency theory was cited much less frequently by staff as justification for their actions in treatments and the clinical director permitted counselors greater freedom to spend time with clients. The clinical director and supervisor who subscribed to codependency theory applied clinical rules in a very partial manner by constraining or terminating clients or questioning the clinical skills of the counselors whom they did not like. It is notable that these codependency advocates were the harshest in their treatment of staff who were more highly educated. Many staff members at both clinics voiced the opinion that the administration had placed such gatekeepers in powerful positions to atomize staff—particularly along sexual-orientational and racial lines—by using such individuals to prevent social solidarities from forming among staff members which could possibily lead to unionization; and to mollify the implementation of the demographic policy guidelines of state funders. The staff also noted that the administration had hired highly-paid, moderately-educated consultants to insure that collective problems of staff be interpreted as individual or process problems.

Another aspect of unconditional negative regard which I would like to illustrate is the application of immediate, coercive, contractual consequences to punish the abuse of an illicit substance without examining the underlying biological, social, and/or psychological causes of the use or alternative healing strategies that could end the use while minimizing relapse. Marguerite Holloway's very recent review of the study by David A. Regier, director of the division of clinical research at NIMH, of 20,291 people from the general community, from mental hospitals, and from nursing homes and prisons, found that 53 percent of those who abused drugs had a mental health disorder such as schizophrenia, anxiety, or major depression (1991, p. 103).

Despite Holloway's observations, at the clinics where I have worked, after an inital written warning that the goal of the program is to be drug-free and that taking illicit substances is against the rules of the program, clients are subjected to a series of gradually harsher consequences after a second "dirty" urinalysis. Yet, it is virtually impossible to get the clinic

physician or family nurse practitioner to prescribe psychotropic medication unless it is in response to a third or more-frequent urinalysis result that tests positive for cocaine. In this case, they are recommended for a "stimulant detox" which costs approximately $135 a month in addition to the methadone fees, to pay for two antidepressants (Imipramine, also known as Tofranil, and Bromocriptine, also known as Parlodel). After seeing every client who went on the stimulant detox quit using cocaine within a month, and after hearing recurring reports of relief from depression and heightened senses of well-being on the part of clients who had never before been on an antidepressant, I modulated my anti-,anti-psychotropic medication bias. I began to agree with Julia Kristeva, who wrote:

> L'effet adjuvant des antidé presseurs est alors nécessaire pour reconstituer une base neurophysiologique minimale sur laquelle un travail psycho-thérapeutique peut s'amôrcer, analysant carences et nouages symboliques et reconstituant une nouvelle symbolicité (1987, p. 50).

Yet, as a sociologist, I became acutely aware, and then angry, that only the small percentage of my clientele who had Medi-Cal or private means of payment could benefit from the psychotropic medication available through the stimulant detox, even when their scores on the highly-reliable Beck Depression Inventory indicated that their level of depression was severe. When I raised this issue on 5 April 1991, at a course on psychiatric medications given by the medical director of Forensic Services of the Department of Mental Health, Substance Abuse and Forensic Services of San Francisco, California, Rich Myers, M.D., replied that this was a systemic problem, and the nods of many other participants in this seminar and my conversations with them afterwards confirmed that psychotropic medication is unavailable to a very large percentage of our clients who need and would consent to take them. Moreover, DSM-III-R psychiatric evaluations, which are a necessary step in getting Social Security Income (SSI) for our clients, take well over a year to receive and, usually, face three rejections and a court hearing from which a class of lawyers specializing in SSI make their living by charging indigent clients a hefty percentage of their first SSI check.

Despite these realities, in a case conference the typical response to a client who does not fulfill a contract to give two clean urinalysis results in 60 or 90 days is to put that client on a drop-per-dirty contract, if the client's dosage is already at the maximum of 80 mg or a raise-per-dirty contract, usually by 10 mg per dirty, if the client's dosage of methadone is not blocking that individual's use of heroin at a dosage below 80 mg. If the client

suffers from extreme depression, often exacerbated by unemployment, lack of childcare, spousal abuse, gender identity confusion, or life in a ghetto where the dealing of crack, smack, grass, and speed is the largest profitable industry, codependency supporters may become angered when a counselor tries to address these problems as underlying or causing that client's second, third, or fourth dirty. Conceptualized in a manner similar to William Bennett's[1] way of thinking, such problems are frequently ignored by the codependency advocate, who acts by increasing or decreasing a client's dosage, by constraining the client to sign progressively more punitive contracts, or ultimately, by terminating the client from the program.

As Robert Bellah and his colleagues (1986) have so aptly pointed out, therapists who resocialize clients in treatment to believe that they must stand alone as individuals against the harsh realities of a mean world, and they must make changes in their lives to face such a dog-eat-dog reality have contributed significantly to the mindset of the extremely individualistic aspects of American democracy. Codependency theory—academically expressed by such authors as Hyatt (1986) and Shipp, Hyatt, and Coler (1988) with its myth of the capable individual standing up to changes within and fighting against attacks from without in a harsh social world—significantly undermines the collective ties that bond people to a community capable of transforming its social and environmental world in order to maximize mental health and to provide a safer milieu for all members of a community.

NOTES

1. Unfortunately, the prospect of such investment is anathema to the likes of William Bennett. In one characteristically acerbic comment, delivered at Harvard's Kennedy School of Government, Bennett remarked how, "on the left," 'we see whole cadres of social scientists, abetted by whole armies of social workers, who seem to take it as catechism that the problem facing us isn't drugs at all, it's poverty, or racism, or some other equally large and intractable social phenomenon. If we want to eliminate the drug problem, these people say, we must first eliminate the :'root causes' of drugs, a hopelessly daunting task at which, however, they also happen to make their living.'

As drug czar, Bennett worked hard to discredit the notion that drug abuse has root causes. But the issue has not gone away. With 1990 on record as America's most murderous year, the need to address the problems of our inner cities seems more pressing than ever. The conservative policy of benign neglect having failed miserably, it's time for liberals to propose an alternative. Investing in the community would seem an ideal place to begin (Massing, 1991, p. 240)

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An Alternative Understanding of the Cognitive, Emotional, and Behavioral Characteristics of Individuals Raised in Alcoholic Homes: A Clinical Theory of the Individual

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ABSTRACT

Historically, clinical sociology has assessed problematic, individual behavior as reflective of immediate social circumstance and situation. As such, practitioners have primarily targeted situational factors contributing to individual distress as areas of intervention. The following paper, however, views problematic, individual behavior as having social origins, yet targets strategies for intervention not at the interpersonal level, but at the intra-personal level—"within" the individual. The logic behind this argument is found in traditional, well-established sociological theory. An analysis of individuals raised in alcoholic homes will be used to demonstrate this perspective.

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Clinical treatment of the individual from a sociological perspective has centered around the individual's "situatedness" within social context (see Swann, 1984). Intervention strategies have accordingly sought solutions through clarification of social context, and ultimately, one's relation to social structure. The emphasis has primarily been on "external" social factors that contribute to problematic behavior for the individual. This is to be expected, due not only to the nature of the discipline, but also to the nature of social reality. This, of course, is not always the rule, nor does this mean that clinical sociology does not address the individual in the context of intervention (see Hall, 1990, and Straus, 1985, for examples).

The following is a clinical theory that finds as its focus of intervention the individual him or herself. This theory proposes strategies that address the treatment of an internalized, unfulfilling social reality. This perspective differs somewhat from other applications of clinical theory, as it places the cause of present problematic behavior not on immediate social situations, nor on current social relationships, but directly on the individual. This is not, however, an example of "blaming the victim." Rather, it is a theory of how the process of primary socialization can result in the internalization of troublesome cognitions, emotions, and behaviors, using as its population of analysis individuals raised within alcoholic homes. Further, this study reveals how these problematic phenomena are maintained and repeated within the course of individuals' lives.

This analysis delves into what has traditionally been considered the jurisdiction of psychology, yet it reaches an understanding of the individual, not through psychological concepts, but rather via traditional, well-established sociological theory. The intention is to affirm the legitimacy of sociology as a means of studying the totality of the individual and to further the clinical endeavor of developing effective and meaningful interventions.

For this analysis, the ideas, concepts, and theories of Mead (1934), Thomas (1923), Cooley (1902), Shibutani (1961), and Berger and Luckmann (1966) will be used. Each theorist's contribution will be examined briefly, with a description of his ideas. These particular theorists were selected because their respective ideas are crucial to the understanding of individual dynamics, but the analysis presented here is not the only one theoretically possible, and other theoretical frameworks would certainly contribute to and benefit the discipline.

Concurrently, the perspective used for the analysis is not one that is exclusive to the population studied (individuals raised within alcoholic homes). This theoretical perspective can be utilized as a clinical framework for other populations or individuals with abusive, unhealthy family histories.

Theoretical Perspectives

Role/Attitude Taking

George Herbert Mead (1934) argued that the development of mind and self is inherently a social process. One is equipped with the biological readiness to acquire mind and self, but they arise only through the mediation of interaction with others.

Mead placed primary importance on language as the vehicle that gives rise to both mind and self because it allows for shared, meaningful gestures between individuals. Language becomes a verbal gesture which brings out in a person the same response that is expected of others, allowing that person to see him or herself reflexively. The importance of this is that individuals are then able to see themselves as objects. This is the foundation for the recognition of selfhood—awareness of self as a separate object.

An individual also has the capacity to take on the roles and attitudes of others, and by doing so is able to become an object in relation to self as reflected by others. A person is further able to gain an awareness of self by taking on the attitudes which others have about him or her. Thus, that individual is able to see himself from the perspective of others, and gain a fuller sense of self.

Looking-Glass Self

Charles Horton Cooley (1902) introduced the notion of the "looking-glass self." This concept sheds light on how an individual develops a concept of self through the imagined reflection of oneself in others. In other words, we define ourselves by how we think others see us. Cooley stated that an idea of self, in actuality, has three elements: our idea of how we look to another, our idea of the other's judgement of ourselves, and a feeling to accompany that evaluation. As such, we not only develop ideas of who we are by how we think others see us, but also develop accompanying judgments and feelings in response to this imagined self-image.

Definition of the Situation

W. I. Thomas (1923) pioneered the idea of the "definition of the situation" as part of the individual's understanding of social reality. One of the essential components of this concept is that behavior cannot be understood devoid of a situational context (Volkart, 1951). Behavior is a response to

the situation in which an individual finds him or herself. A second component is inherent in the first, i.e., that the individual must "define" the situation before he or she can act in relation to it. This introduces the subjective element of the individual within the social context. As Volkart (1951, p. 7) notes, "...the 'definition of the situation' is the crucial link that connects experience and adjustive behavior to the situation." One must first understand the situational context in which one finds oneself. Once this is established, behavior is initiated as adjustment to the now-defined situation. The behavior is predicated on the understanding of the individual and the individual's situation.

Adjustment and Adaptation

Tamotsu Shibutani (1961) offers a deeper subjective understanding of individual action within social context. Specifically, he explores behavior in relation to the adjustments made by an individual in response to situations that are defined as problematic. Shibutani demonstrates how Freudian defense mechanisms such as repression, regression, and projection can be understood from a social-psychological context. He reveals how these can be seen, in essence, as adjustments to various social situations that an individual encounters. If the individual defines a situation as being potentially harmful, he or she may respond in ways that will provide protection from the situation. In this manner these subjective individual adjustments leave the realm of the traditionally psychological unconscious and enter into the world of social reality.

Another concept that Shibutani develops is the idea of adaptation (1961, p. 87). This is characterized by "...a peculiar combination of techniques for coping with difficulties...." The techniques are "...well-organized ways of coping with typical problems which become crystallized through a succession of adjustments." These can then become part of the personality, as established behavioral responses to certain situations. Adaptations can also be generalized to similar problematic situations.

Truth

A valuable insight offered by Berger and Luckmann (1966) is the notion of "truth" about self and the world as understood by a child. They note that a child is unable to choose into which family he or she is born. As such, children are unable to willingly choose with whom they identify. Hence, they internalize the roles and attitudes of their significant others and, in the process, internalize their significant others' reality. They do not internalize

a pluralistic reality, but rather, internalize their parents' reality as "...*the* [original emphasis] world, the only existent and only conceivable world... (Berger & Luckman, 1966, p. 134)." The importance of this lies within the impact that this has on the individual in later life. "It is for this reason that the world internalized in primary socialization is so much more firmly entrenched in consciousness than worlds internalized in secondary socializations (Berger & Luckman, 1966, p. 135)." This sheds light on the impact of primary socialization on the maintenance of certain cognitions, emotions, and behaviors.

Review of Current Literature on Individuals Raised in Alcoholic Homes

Recent studies of adult children of alcoholics have found that they are more susceptible to developing problems with alcohol and drugs (Pandina & Johnson, 1990; Parker & Harford, 1988); have an increased chance of antisocial personality disorder (Cadoret, Troughton, & O'Gorman, 1987); exhibit a higher incidence of psychopathology (West & Prinz, 1987); are more likely to experience marital disruptions (Parker & Harford, 1988), and have more problems with issues of emotions, trust, interpersonal communication, and control (Cermak & Brown, 1982).

There exists a large pool of popular literature on alcoholic families and the personality characteristics of individuals raised within alcoholic homes (see Ackerman, 1983; Black, 1981; Bradshaw, 1988; Woititz, 1983). This literature, based on clinical observations and case studies, provides a rich, description of life in the alcoholic home, which is lacking in empirical studies. The literature includes descriptions of the emotional, cognitive, and behavioral characteristics of individuals raised in alcoholic homes. For the most part, growing up in alcoholic homes as depicted in these works is characterized by the development of protective and defensive traits in response to the alcoholic environment. These traits prevail throughout the adult life of these individuals, giving rise to the realization that their condition is a traumatic and lifelong burden that they must endure.

These troublesome behavior patterns affect the individual throughout his or her adult life. Accompanying these patterns are feelings of deep shame, inadequacy, low self-esteem, and poor self-concept. The individual often believes that there is something "wrong with him or her." These individuals are frequently unable to see the impact of social context on their lives.

Overall, the accepted explanation for the manifestations of these behaviors is often of a psychological nature. Even though "others" are taken into

account when explaining the emergence of problematic behavior, the popular perspective lacks the sociological understanding of the development of self, and as such, is unable to present a comprehensive treatment of this phenomenon. This is not to say that there is no acknowledgement of social context within these works. The popular literature has popularized the idea of "dysfunctional families," so there is "sociology" within these works. However, the sociology contained within them is latent—it is neither acknowledged nor directly referenced, and, most importantly, it is not developed to the extent that it could be to ensure the most life-enhancing intervention.

Analysis of Cognitions: Impact of Parental Roles and Attitudes on Self-Concept

A child is born into a family unsocialized, as Parsons (1951) notes, a "barbarian." Within this family, the child learns the skills necessary to live, and develops a self through the process of interaction with family members. From a Meadian standpoint, as part of the process of developing a self, the child takes on the roles of significant others. This process occurs within any family, alcoholic and non-alcoholic alike.

The clinical literature on alcoholic homes indicates that parenting styles and parental roles can frequently be inconsistent, chaotic, uncompromisingly rigid, or a combination of all three (see Black, 1981; Bradshaw, 1988). In such an atmosphere, the maturing child takes on roles that are not necessarily appropriate (Fein, 1990). An alcoholic parent may lie, rage, become physically violent, and/or abuse family members, and the child growing up amidst this behavior may take on these dysfunctional roles. The model of self portrayed by alcoholic parents is one that, on its own, reflects chaos, pain, and torment. Living out these roles, the child, who later becomes an adult, experiences to some extent the same difficulties in life that the alcoholic parent encountered.

The child may also take on attitudes corresponding to these roles which may be painful and abusive in relation to self, others, and the world. Attitudes toward the child that alcoholic parents reflect back to the child are often degrading, hurtful, and shaming. The child, in response, gains a sense of self that is inevitably negative and shameful. A non-alcoholic husband, for instance, may tell his daughter in anger that she is "just like [her] mother." If the child identifies the mother as an abusive, rageful alcoholic, she may internalize a sense of self that reflects mother, i.e., a negative and shaming sense of self.

The child defines "self" from what significant others say about him or her. If they describe the child as bad, a bother, or as stupid, the child may responsively internalize attitudes of self that reflect these qualities. A child developing a self through interaction with others, taking on attitudes about self from significant others, can only respond in this way.

The child, then, knows him or herself from reflections of family members, and in alcoholic families, the reflections can be disproportionately negative. As such, the cognitions about self become inherently distressing and ultimately life-inhibiting.

With the application of Cooley's concept of the looking-glass self, it becomes more apparent why children of alcoholics develop low self-esteem and poor self concept. If they imagine that their parents see them in a negative light, i.e., adopt the negative images of self that have been presented by parents, they will judge themselves as such, and will have negative feelings in response. Children of alcoholics often think that their parents see them in negative ways, as this is often how alcoholic parents address themtelling them that they are "dumb," "no good," "crazy," etc. They imagine that their parents see them negatively, evaluate this negative image in a concurrent manner, and feel shame and self-loathing in response. If parental behavior consistently reflects negative attitudes about child's self, poor self-image will be reinforced, and will be internalized as self-concept.

As Berger and Luckmann have pointed out, the world that children come to know and understand is the world according to their parents. They accept as truth that which their parents tell them. Thus, the attitudes of self that children receive from their parents are accepted by the children as the truth about them. This phenomenon solidifies even further the negative self-concept that the child has internalized. The years of internalization of negative self attitudes compounded with the belief that these attitudes are the truth about themselves create a legacy of pain that adult children of alcoholics live and suffer with for many years. As Berger and Luckmann note, the effect of primary socialization is significantly more "entrenched" than secondary socializations, leading to the maintenance of a painful self-concept, even throughout adult life.

Behavioral Responses to the Alcoholic Environment

Thomas' definition of the situation and Shibutani's concept of adaptation aid in understanding behavioral characteristics common to children and adult children of alcoholics. Shared by both theorists is the notion that social actors interpret their environments and act in response to their defi-

nition of the situations—individuals raised in alcoholic homes respond no differently.

If a child defines the situation in an alcoholic home as threatening or out of control, he or she will respond in a way that offers maximum self-protection. Their adjustment to these harmful situations will often be by some form of defensive posturing. If both the situation and the interpretation of threat persist, which is often the case in alcoholic homes, the child will begin to respond to these situations in an "adapted" manner. He or she will cope with the situation by adapting, rather than adjusting to the situation in a healthy way. To a certain extent, there is no other reasonable way to "adjust" than to adapt. This, then, becomes the child's primary means of interaction with the world. Berger and Luckmann's thesis applies here as well—the "truth" about the "world" is that it is primarily threatening, and one must be "on guard" against it.

Accordingly, the child will often generalize these defensive postures in response to other potentially threatening situations that recall those in the home. These adaptations become unhealthy, automatic, internalized behavioral responses to both home and social situations. Unfortunately, as noted, these adaptations often become the primary means of interaction as adults, as well.

As reported in the literature, some common adaptations of individuals raised in alcoholic homes are rigidity, overcontrolling of self and environment, compulsivity, alcohol abuse, addiction, and psychopathology.

Implications for Intervention

After reaching a sociological understanding of an individual's problematic thoughts, emotions, and behaviors, the sociologist is able to develop a number of specific interventions. The sociologist's primary assessment should be to determine if the individual comes from an alcoholic home. If the determination is made that this is indeed the case, then the practitioner could proceed with several strategies.

Initially, an individual can benefit from education and elucidation about how painful thoughts, emotions, and behaviors arise through interaction with family members, i.e., how self is formed. This helps the individual to understand the origin of these painful phenomena, and also makes clear that these thoughts, emotions, and behaviors are all subject to change—the internalized familial "truth" about self can be challenged. The individual can engage in the redefinition of self. With this information, the individual is able to begin the process of self-resocialization—intentionally replacing

negative self-images, attitudes, and behaviors with more positive, life-affirming ones.

The individual needs to understand that the origin of the problematic behavior is primarily of a social nature, and that it is the "reflected" content of self that is problematic, not the individual him or herself, per se. Once this is understood, however, the individual must also realize that knowing the origin of the problem does not, in and of itself, alleviate the problem. Rather, the individual must come to realize that although there were others who contributed to his or her current condition, the process of change is solely the responsibility of the individual him or herself. This is often a frustrating and difficult awareness to cultivate for both the client and the practitioner.

One does not have to "go it alone" in the process of change, however. Self-resocialization can be significantly enhanced and promoted by attendance at the appropriate self-help support groups (for example, Adult Children of Alcoholics, Al-Anon). Overall, these groups aid in the resocialization process by providing a new group of significant others who support and welcome positive, individual change. Since self is ultimately a social process, surrounding oneself with others who are committed to developing healthier, more life-affirming selves can serve to reinforce the individual effort to reconstruct a more positive self.

The individual can also be taught the sociological view of self as a process, and how it can constitute a flexible reality. This knowledge can offset the internalized behavioral adaptations to certain situations that result in fear and/or frustration. Adaptive behaviors can be challenged and problematic situations can be redefined through the process of therapeutic role-play. Replacing troublesome adaptations with more viable or healthier responses to situations can not only decrease anxiety, but increase self-esteem.

Other, more directed interventions can also be implemented. The reenactment of family roles through sociodrama can reveal further information about family dynamics and environment. One-on-one sociotherapy might prove useful by challenging inhibiting conceptions of self or harmful or self-destructive behaviors. Inviting current significant others to participate in the therapeutic process is another possible intervention.

If the adaptive behavior falls outside of the practitioner's area of expertise (for example, if the individual is engaged in active addiction, alcoholism, or some other potentially life-threatening adaptive behavior), other interventions may be necessary, and referral to the proper resource may be required.

Discussion

The purpose of this paper is to develop a distinctly sociological, clinical theory of the individual that can offer understanding into problematic behavior, and to propose tailored strategies for intervention. As demonstrated, our current theoretical base allows for powerful clinical analysis of not only interpersonal dynamics, but also of "intra"-personal dynamics. To be sure, the insights that traditional sociological theory affords the practitioner for developing effective interventions on an individual level are extensive and invaluable.

In this particular example, Meadian theory of the development of the self can offer an individual with low self-esteem a perspective on how "self" was formed. Through recognition that formation of self is ultimately a social process, the burden of shame for an "ineffective" and unfulfilling self is alleviated. The "fault" for problematic and painful behavior is retrospectively redistributed among responsible family members. Thus, traditional theory itself can be used as an intervention when disclosed in an understandable way to the individual seeking help.

There are those who have argued that some sociological theory "loses" the individual. As is revealed from the above analysis, this is not the case with all social theory. In fact, our theoretical history is resplendent with clinical insights, concepts, and ideas for interventions. All that is required of the practitioner is to see "...the relevance that sociology and its theoretical perspectives have for daily living and for change toward more fulfilling behavior and relationships" (Cohen, 1981, p. 4).

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Intervention among Children of Substance Abusers and School Success

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ABSTRACT

In substance abuse prevention literature findings indicate that children who grow up in households where there is alcohol and other drug abuse are much more likely to exhibit problematic, dysfunctional behavior, such as delinquency, drinking and drug use The purpose of this study was to assess the applicability and effectiveness of intervention among African-American children of substance abusers, particularly in terms of school achievement. A modified version of the student assistance services model was used. Specifically, this study examined the impact of the independent variable—the number of times the student participated in the counseling program, on the dependent variables of interest fourth quarter grade point average and fourth quarter absenteeism as documented in final report cards. The results indicate that this intervention technique of socialization of at-risk youth toward alcohol and other drugs and toward coping with addiction in one's family improves academic performance among African-American youths.

Introduction

Review of the Literature

In substance abuse prevention literature, findings indicate that children who grow up in households where there is alcohol and other drug abuse are much more likely to exhibit problematic, dysfunctional behavior, such as delinquency, drinking and drug use (Kandel, Kessler, & Margulies, 1978; Hawkins, Lishner, Jenson, & Catalano, 1987; Kumpfer, 1987). This has spawned recent attention by the federal government and private counselors to specifically address the needs of these children (Brown & Mills, 1987; NIAAA, 1985; OSAP, 1988, No. 4). At a recent conference of the National Association of Children of Alcoholics, held February 28-March 3, 1988, in New Orleans, it was estimated that about 20%-25% of American students are children of substance abusers (Moe, 1988). This estimate has also been cited in government literature (NIAAA, 1981). Some of the many problems associated with children growing up in family environments where there is substance abuse include: (1) school problems, such as trouble with schoolwork, academic failure, early dropout, excessive absenteeism, temper tantrums, fighting with peers, and trouble with adults (Haberman, 1966; Kumpfer & deMarsh, 1986; Morehouse, 1979) ; (2) substance abuse problems, such as heavy drinking and increased drug abuse (Barnes, Farrell, & Cairns, 1986; Johnson, Leonard, & Jacob, 1986); (3) emotional disturbances affecting social and family relationships, including emotional instability, lower self-regard and self-acceptance, higher external locus of control, higher rates of suicide, and chronic depression (NIAAA, 1985, p.7); (4) emotional neglect and physical abuse (Booz-Allen & Hamilton, 1974, as cited in NIAAA 1985; NIAAA, 1980; Woititz, 1983).

Purpose of the Study

Despite the increased attention and research which has recently been devoted to the condition of children of substance abusers, gaps remain in our understanding of the many ramifications of this condition, particularly in the area of helping these children before further negative consequences can take hold. One such gap in knowledge is the effect of intervention efforts on school achievement and positive school behavior. Another gap is the role of cultural issues in intervention with children of alcoholic and drug-abusing families, particularly the impact of intervention upon different cultural groups (NIAAA, 1985). This article, a report of findings from

an intervention counseling program administered among African-American children of substance abusing families, addresses both of these gaps.

As a sociologist, the author saw the intervention as having aspects of a primary socialization as well as a resocialization process. The main agents of primary socialization, the school, the peer group, the mass media, and the community, were involved in carrying out this intervention. The school provided the setting for the socialization and students to be "socialized". The counseling took place in small peer groups and although the groups were facilitated by professional adult counselors, peer-to-peer interaction prevailed. The mass media, particularly videotaped vignettes depicting family alcoholism, peer resistance techniques, and information about the effects of alcohol and drug abuse was used to elicit group discussions. Today's adolescents, even those who are unsuccessful in school, not inclined to read, or have short attention spans, are very receptive to audio-visual media, such as, films, videotapes, and "rap" music. The community took the form of the counselors, who were African Americans themselves, from a community-based substance abuse prevention program that was external to the schools and school officials. This externality feature was important in getting the students to participate openly in their discussions, without feeling afraid of being penalized by teachers or other school officials. The author felt that incorporating all of these features would serve to strengthen the effects of the socialization. The family was not used as a means of socialization in this program. The author does not rule out however, incorporating the family, especially extended family members of children of substance abusers, in future studies.

As previously mentioned, the intervention also had aspects of the resocialization process, or being exposed to ideas or values that in one way or another conflict with what was learned in one's childhood. In many ways, intervention with children of substance abusers can be seen as a form of resocialization. Because such children have often been deprived of basic emotional validation, and sometimes even basic physical care, and have learned survivor roles that are inappropriate and mentally unhealthy, true intervention would necessitate them unlearning the values, rules of conduct, and role expectations into which they were socialized within their dysfunctional family groups. Since such children live in social groups where alcohol and other drug abuse and even illegal drug trafficking are the norms, true intervention would require these children to unlearn norms and values displayed by their immediate families and their community.

What was also appealing to the author in terms of the intervention as a socialization and resocialization process was its reliance on small primary groups, in this case support groups, as a means of carrying out these pro-

cesses. Primary groups, characterized by intimate, face-to-face associations, are basic to the development of the social self (Cooley, 1909, p. 23). Primary group socialization and resocialization through peer support groups may be necessary in order to counteract the damage that has been done by other primary groups, such as dysfunctional alcohol and drug abusing families, and drug-ridden neighborhoods.

Further Explanation of Study's Purpose

A modified version of the student assistance services model, developed by Ellen Morehouse of Westchester County, New York, for children of substance abusing families was used as a basis for the socialization/resocialization intervention. (See NIAAA, 1984). The Westchester student assistance services model had had some success as a socialization/resocialization tool among children of substance abusers who were predominantly white high-school students in northern, urban areas. The Westchester model reported success in terms of reduced self-reported drug usage and increased anti-drug usage attitudes (Morehouse & Scola, 1986; Morehouse, 1986). Having access to the New Orleans public schools, the author wanted to pursue the applicability of this socialization/resocialization tool with other social groups, particularly younger, southern, urban African-American, working-class students. Moreover, in contrast to the Westchester study's focus on attitudinal indicators of alcohol/drug abuse prevention, the author wanted to focus on behavioral indicators of change, such as students' grades and school attendance. It is well-known in the substance abuse prevention arena that relying on students' self-reported usage of alcohol and drugs may not be as accurate as one would like, and attitudes are vulnerable to reactive bias (French & Kaufman, 1984, p.42). Hence, the use of school performance and attendance as measures of program outcome. The use of these indicators as measures of program success is accepted in substance abuse prevention literature from a methodological standpoint (French & Kaufman, 1984, pp. 42-44). In addition, research findings show academic failure to be an indicator of adolescent alcohol/drug abuse (Jessor, 1976; Robins, 1980; both as cited in Hawkins et al., 1987) and indicate that adolescent drug users are more likely to be absent from school and to cut classes (Brooks et al., 1977; Kandel, 1982).

As administrator of a community-based substance abuse prevention agency, the author had the opportunity to implement and conduct a program evaluation of an intervention undertaken with 116 at-risk, middle- and junior high school students from the New Orleans inner-city public schools in the 1988-1989 school year. The author's hypothesis was that drug pre-

vention counseling intervention would have a positive impact on middle- and junior high school African-American children of alcoholic and other drug abusing families, and on other at-risk youths, in terms of academic achievement and school attendance.

Specifically, the study examined the impact of the independent variable, the number of times the student attended the counseling sessions, on the dependent variables of interest: fourth quarter grade point average and fourth quarter absenteeism as documented on final report cards. Other independent variables were controlled, including: school of origin, grade level, previous grade point average, and previous number of times absent. Gender and race were not used as control variables, since gender cross-tabulations resulted in no noticeable differences, and about 95% of the sample was African-American anyway.

Limitations of the Study

Limitations of the study included the relatively small sample size, the fact that the sampling was based on referral from school officials, such as counselors and teachers, and the short period of intervention. The small sample reduced generalizability somewhat, but the targeted population of children was also small compared to the total population of children. The population of interest, children of substance abusers, was identified by personal recommendation of counselors and teachers, using indirect indicators, such as chronic absenteeism, sleepiness in class, behavioral problems in school, and poor grades (Morehouse & Scola, 1986, pp. 3-7). Age of student and socioeconomic status of family were also not controlled in this study. However, due to the compact nature of the targeted grade levels, most of the students fell in the age group of 11 to 14 years old. Also, since all of the students were recruited from inner-city public schools, the sample primarily reflects a working-class, African-American population.

Further Description of the Study

Subjects

The subjects who participated in this intervention program were 116 male and female students enrolled in three middle- and junior high public schools in New Orleans during the 1988-1989 school year. The schools were selected with the support and cooperation of the Orleans Parish Public Schools, Drug-Free Schools, and Support Services Departments. This

helped in dealings with the educational bureaucracy. First and foremost, referrals were made by the respective school counselors and teachers for students whom they suspected to be children of alcoholics or substance abusers. Other students were referred based on their problem behavior record, high absenteeism, suspected alcohol and drug abuse experimentation, social isolation, and low grade point average—all indicators of children of substance abusers. The sample was 75% male. The three schools, School 1, School 2, and School 3 comprised 32%, 28%, and 40%, of the sample, respectively. The students ranged in grade level from sixth through ninth grades, with 22% in sixth, 22% in seventh, 29% in eighth, and 28% in ninth grades. The median grade point average for the sample's first quarter report card was 1.35, or a D, average. At the end of the second quarter report card period, just before the intervention services were to begin, the median grade point average was 1.14, also a D average. The median number of days absent for the first quarter report was three, and for the second quarter report, just prior to intervention services, the median number of days absent was five. The sample was about 95% African-American.

Collection of Data

The Project was administered by the community-based substance abuse prevention center, which was external to the public school system's Drug-Free Schools program. This externality was one of the core concepts of the intervention, and was done to ensure the confidentiality and openness of the students' discussions and to eliminate the need for prior parental consent. In most schools, guidance counselors are in close contact with parents and other teachers, and could inhibit frankness on the part of the students, as the students might see their discussions as potentially jeopardizing to their grades and chances of promotion in school, not to mention their relationships with their parents. These were very sensitive issues, particularly for children in substance abusing households. In addition, the externally-based program provided students with access to professionals specially trained in working with youth experiencing stress associated with family addiction (NIAAA, 1984).

The direct counseling services were provided by a full-time counselor, with part-time assistance from a social worker also based at the community drug prevention center. Both were African American females with master's degrees. Their racial status helped in establishing a rapport with the students. The primary method of intervention with the students was a combination of structured socialization and resocialization activities. This took

the form of structured support group counseling about alcohol and other drugs, along with less structured group sessions on family addiction problems and how to cope with them. Peer pressure resistance techniques, alternatives to drugs, identification and communication of feelings, and identification and use of community resources to cope with family addiction problems, were some of the topics covered over the period from late February through the end of May, 1989. This corresponds to the third and fourth quarter report card periods, respectively.

Students were divided in all three schools into small groups averaging about seven students per group. There were 17 groups between the three schools. Each group met weekly, with students rotating meetings so as not to miss the same class every week. The number of counseling sessions attended by each student ranged from 0 to 11.

Problems Encountered

Some problems were encountered in the course of the project. One in particular, was the delay in starting the project, due to delay in funding from the granting agency. This reduced the amount of time available for providing counseling sessions. However, this also provided the advantage of allowing the school officials to have a basis for their referrals in terms of the students' behavior, grade point average, and absenteeism in the first two report card periods. This also afforded the author a basis for before-after comparison for all of the students in terms of absenteeism and grade point averages within the same school year, rather than across school years, as was originally planned. In hindsight, this reduced problems of maturation effect.

Another problem, initially, was getting students to remember their group session schedules. Announcements over the loudspeaker were used at first to excuse them from their classes to attend the counseling sessions. Eventually, a second social worker assisted the main counselor by going to the classrooms to retrieve the students for the group sessions.

Analysis of the Data

Techniques of the Analysis

The data obtained for each student included: school attended, gender, grade level, grade point average and number of whole days absent from school as reported for four quarters on students' report cards, number of

times student participated in the counseling sessions, level of perceived student participation in the sessions, and level of perceived student progress in the program. The data were analyzed using subroutines from the Statistical Package for the Social Sciences (SPSS, 1988). A multiple regression analysis was conducted using grade point average and number of days absent as dependent variables. The independent variable under consideration was the number of times the student participated in the program's counseling sessions. The variable was dichotomized into low program attendance, or attending five or less times, and high program attendance, or attending six or more times. Control variables included were school attended, grade level, grade point average before inception of the program (second quarter grade point average), previous absenteeism level (number of days absent during second quarter), and the interaction effect of school and grade level. The grade point average variables were dichotomized into high (average of C or above) and low (average of D or below). Categorical or dummy variable analysis was used for the remaining nominal and ordinal level variables. The .01 level of significance was used for all statistical comparisons.

Description of the Findings

Tables 1 and 2 illustrate the results. In Table 1, the results indicate that receiving a grade point average of C or better in the quarter report card period is significantly associated with more frequent attendance at the counseling sessions, with a $p < .01$ level of significance. This is so even when controlling for the other independent variables of interest discussed previously. As was expected, receiving a C or better in the previous report card period was significantly associated with receiving a C or better in the fourth and final report card period. Note, too that the total variance explained by all the variables in the equation is relatively high, over 40%.

Table 2 depicts similar results. Lower absenteeism in the fourth quarter is significantly associated with program attendance, at $p < .001$ level of significance. Also, the variables in the equation explain a little more than 25% of the variance in fourth quarter absenteeism, which is not as much as that explained in fourth quarter grade point average equation, but it is still substantial.

Table 1. Regression Analysis of the Relationship between the Dependent Variable—Fourth Quarter Grade Point Average and the Main Independent Variable—Program Session Attendance

(n=116)

Independent Variables	Fourth Quarter Grade Point Average		
	Beta	Partial Correl	T
Grade Point Average-Second Quarter	360	.315	4.27**
Program Session Attendance	.272	.242	3.28*
Absenteeism—Second Quarter	-.102	-.093	-1.26
Grade 8	.168	.082	1.11
School 3	-.102	-.050	-0.68
School 2/Grade 9	.132	.057	0.78
School 1/Grade 7	.126	.073	0.99
School 3/Grade 6	.064	.043	0.58
constant			2.19
		R^2 =.412	F=9.46**

** $p \leq .001$
* $p \leq .01$

Note: - = negative correlation (inverse relationship depicted); Blank = positive correlation.

Table 2. Regression Analysis of the Relationship between the Dependent Variable—Fourth Quarter Absenteeism and the Main Independent Variable-Program Session Attendance

(n=116)

Independent Variables	Fourth Quarter Grade Point Average		
	Beta	Partial Correl	T
Program Session Attendance	-.383	-.340	4.14**
Absenteeism—Second Quarter	.214	.195	2.38
School 3/Grade 6	-.227	-.151	-1.84
School 2/Grade 9	-.349	-.151	-1.84
School 1/Grade 7	-.230	-.133	-1.62
Grade 8	-.233	-.113	-1.38
G.P.A.—Second Quarter	.032	.028	0.35
School 3	-.052	-.025	-0.31
Constant			4.76**
		R^2 =.270	f = 4.97**

**$p \leq .001$
*$p \leq .01$

Note: - = negative correlation (inverse relationship depicted); Blank = positive correlation.

Conclusion

The results indicate that the intervention technique of socialization and resocialization of at-risk youths toward alcohol and other drugs and addiction within the family, has successful outcomes across the various social groups, including race, region, social class, and grade level. Hence, this approach has applicability for southern, African-American, working-class, adolescent males. Moreover, the success in behavioral changes in grade performance and attendance reinforces earlier findings of attitudinal changes from a similar intervention in New York.

Secondly, the results have shed light on the effects that substance abuse intervention can have on academic achievement among children of substance abusers. As can be seen, intervention in this special high-risk population does seem to improve academic achievement, which can be a protective factor against adolescent substance abuse. This is in contrast to evaluation studies cited previously, which only documented improvement in drug usage behavior and attitudes. It is still speculative, however, how long lasting these academic improvements will be.

Finally, the intervention program and its evaluation demonstrate a variety of ways in which sociologists can make contributions to the field of alcohol/drug abuse prevention. The author, a sociologist, designed, received funding for, staffed, monitored, and evaluated the intervention as part of her duties as overall director of the community-based substance abuse prevention center under which the program was operated. While this may seem problematic for maintaining objectivity, the sociologist can wear, and, in fact, often must wear several hats in the applied arena. Carefully documenting data and keeping tab of one's different roles helps in this regard. Networking with other social science, and sociology professionals in similar settings also helps. Recently, government funding sources in the alcohol and drug abuse prevention and AIDs prevention fields have begun to emphasize the importance of program evaluation and have encouraged self evaluation even on a small scale, furnishing written guidelines and even technical assistance in many instances. With the prospect of limited human services funds and the enormous challenges of social problems, such as alcohol and drug abuse, AIDs proliferation, teen pregnancy, and homelessness, just to name a few, the sociologist in these applied settings as administrator or practitioner should be encouraged to undertake evaluation as part of his/her role, if not to render insight to the sociological discipline, then to at least improve the quality of program service in his/her area.

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Cross Cultural Intervention III: Some Corrections and an Update in The Case of the Hexed Hair

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ABSTRACT

This is the third short article about Ms Koslowski, a woman who overcame an eleven year hex on her hair. It provides an update, corrects some mistakes, and presents an analysis

Introduction

This article is the third installment of "The Case of the Hexed Hair." The first article[2] presented a cross-cultural intervention that showed how specialized cultural beliefs stemming from folk culture were used in the development and implementation of a treatment plan that successfully aided Ms. Koslowski to eliminate an eleven-year hex on her hair, which had not allowed it to be cut. At that time, Ms. Koslowski carried a seven pound, thick, tangled mass of hair, which she concealed under a waist-length wig. The treatment planning included researching the role of white magic within

Polish folk culture in Europe and the United States. The treatment itself required Ms. Koslowski to find and then use the services of a healer to perform the necessary white magic to permit the cutting of her hair. A social worker, a psychiatrist, and I provided supportive therapy. Father Karon, a Catholic parish priest, who received permission from the Monsignor, aided in the locating of Doc Jones, the black healer, and provided religious support throughout the removal of the hex.

The first article on this case was written from my perspective, and used the case to illustrate a clinical sociological cross-cultural perspective. Ms. Koslowski shared the first article with persons who had helped her or who needed to understand her background. However, she felt there were some inaccuracies in the first article and felt it was quite important to set the record straight. We worked together on the second article which corrected some inaccuracies and included an update of her progress. However, the wrong draft of the article was printed in the *Clinical Sociological Review*.[3]

Part I

I believe (and Jonathan Freedman concurs) that it is quite important that the information in the article about me be correct. The major corrections are:

•My mother did not practice white magic.

•I did not bury anything at the cemetery; Doc Jones did the burying.

•When Doc used the word "sin," he substituted that word for spells, so as not to give glory to the Devil.

•The book with my name on the inside left front cover, I believe, originated at a Black Magic Cult which a friend of the witch attended with a friend of our family. This friend told my mother about the visit to the cult. My mother told the Monsignor about this. He agreed to receive the book and remove my name from it. He held the book until the healer was found. The healer accepted the book and made certain markings in it.

•When I started to collect recipes, it was for my own use in cooking. Then, after acquiring lots of recipes and knowledge about cooking, I planned to write cookbooks. I still plan to do this.

•Easter is the best time to overcome spells, because of the Resurrection of Jesus and His triumph over evil. Christmas Eve is also a good time.

Here are some clarifying additions:

I recall that the night before Thanksgiving in 1976, before the hair appeared hexed and matted, and after I was tipped off by a friend that my

neighbor must be a witch, I put myself in God's hands, thought a simple prayer, and ended the prayer, saying that only God could get me out of this mess. The next afternoon I went into the kitchen and an almost inaudible spiritual voice off to my right said, "yell!" I hesitated and thought to myself that if I yelled people would say that I was crazy. I resisted yelling at first. I then got a message that if I yelled at the witch, I would, after a certain time, get well and go to work. If I didn't yell, the voice said, "this (the witchcraft) would go as it's supposed to." So I yelled. I thought one time would be sufficient, but I realized that I must continue to yell until the fight with the witch was over and the spells were overcome. It seems almost finished now.

In March of 1977, I went to see a psychic who knew that I had hexed hair, even though it was covered with a hat. She gave me Doc Jones' name and told me how to contact him and that he was a man of God. She also told me that my next door neighbor was a witch and a devil and that I would need to give the spell back to the witch. A few days later, I confronted the witch by yelling at her "witch hexer," and telling her she caused the hexed hair. She herself admitted that she caused the hexed hair when she said she was happy that she could do that to me. I replied that she should not be happy because God is not happy and Jesus is not happy. She became silent then. After she gloated, my name-calling became a lot stronger and nastier, to make her unhappy.

Then in the summer of 1988, after the hexed hair was removed, she laughed and said 'a Black' helped you."[4] I cut her off. The next day she asked, "How are the Blacks today?" in a mocking tone. I cut her off again. After thinking the situation over for a few days, I asked her how she knew that the healer was black. She said that I had said so. I replied that I had never said he was Black, only that a healer had helped me. She twisted her face and shut up.

Three weeks before my father died, he said, "Is that witch going to kill us all?" He took my mother to a healer in Poland, who removed a spell from her right knee. If she had not gone to the healer, the bones would have come out of the knee. White spots where the bones were supposed to come out of her skin remained for the rest of her life. My father believed, but he kept it more to himself. My mother and I were more active. My mother was treated by a medical doctor in the U.S. for problems with her big toe. He came to believe that the toe was hexed by the witch when bones came out of it.

I still believe that the next door neighbor is a witch. She continues to stare at my house. When she backs out of her driveway, she pulls up to the left curb instead of to the right side of the street, and stares into my

house. There is no reasonable explanation for her to do this, unless she is up to evil. It seems to be some sort of ritual. She does this several times and then stops. I run into problems, especially with my family and tenants, after she does that.

Doc Jones helped me a lot. The witch continues to try tacky stuff, but nothing she has done has deeply affected me, except to cause a lot of inconvenience. She seems to try and get to me each year on the same dates on which she caused me trouble before.

There is a court battle going on with my sister over the ownership of my parents' house, which should be half mine. I took the initiative and sued her after she tried to evict me several times. The case has not yet been settled.

I continue to study music at the community arts school: voice lessons, ensemble singing and some solos: including country-western, easy listening, Polish and religious music. I also study music composition with a private instructor. I have written lyrics in the past and have a few pieces set to music. I still buy glittery clothes for performances. I sang my first-full length solo and duet at the Community Art School Open House and received applause and many compliments.

I will go to the Hutchings' outpatient clinic until I reach a satisfactory conclusion to the witchcraft problem and tie up some loose ends. These visits also concern family issues, especially involving my sister. I work at Cedar Industries, the Hutchings' workshop, doing piecework. I put together at least one thousand cable connectors an hour. It pays over $8 a thousand. I am almost ready to take a full-time job and to leave the Hutchings mental health system and social services.

I like my hair. It is no longer hexed. It's getting longer and stronger looking. I now wear wigs only when I feel like dressing up, not because I have to.

I never took medication as part of my treatment at Hutchings. I was never an inpatient. I was originally brought to Hutchings after my mother had a stroke and became a mute invalid. Members of my family tried to put me on welfare and wanted to throw me out of the house and take the assets once it was sold. If my mother had not suffered the stroke, I would not have wound up at Hutchings.

I go to Cathedral frequently, and to St. Kasimars on occasion. I am still in touch with the priests who were helpful. I live one day at a time, with a strong faith, trusting God that things will work out for the best. I feel God's protective hand upon me. I believe that dealing with spells and hexes is dealing with the supernatural. The supernatural is hard to understand or prove. For example, healing miracles in Lourdes or Fatima and

divine healing in general are done with the help and grace of God, Jesus, and the Holy Spirit. I believe that I was helped by these forces. Spells and evil miracles are done with the help of Satan, through black cults and Satan's followers.

Part II: Discussion

The Quality of Contact between Us

Please note the shift in Part I of this article. No longer is Sophie Koslowski speaking through me. This part of the article was written in the first person. Although Ms. Koslowski chooses to continue to use the pseudonym, these are her words to describe her concerns and the changes in her life. My function in this part of the article is to try to limit the detail in her story and to act as scribe. She writes well and I have encouraged her to write an autobiography.

I am not sure her words in the first part of the article convey the quality of our interaction. Sophie Koslowski is empowered, perceptive, assertive, articulate and on the move. The power, once in her hair, now flows within her. She has goals and is working hard to achieve them. While she insists strongly on what is important to her, she is open to compromise.

I am no longer a usual therapist, but rather have become one of the persons Sophie Koslowski touches base with, partially as an advice-giver, but more specifically as someone with whom she can share her achievements and problems. This role has developed over time. At the time of the first article, I was part of a three person team, consisting of a primary therapist social worker, a psychologist, and a clinical sociologist which met with Ms. Koslowski to assess progress. Once the formerly-hexed hair was removed, Ms. Koslowski came by, as per the instructions of the healer, to show me the hair. She then began to touch base informally at about three week intervals. Sometimes, it was to show me a new acquisition from the consignment clothing store, sometimes it was to use the copier in the library to copy music, and sometimes to tell me the latest escapade with the witch or her family. This has become an informal role. I am not part of her formal treatment, but the meeting team acknowledges my role. I seldom give advice. Rather, I am a navigational point by which she can check her bearings.

This informal professional role provides a continuity over years, not just for Ms. Koslowski, but for former students, clients, community members,

co-workers, and others. The closest natural metaphor is a long-term casual friendship—one that is available when needed, but which will not escalate. I think my role has developed because I am easy to access, a good listener, accepting of alternative belief systems, and non- judgmental. Many mental health workers play this role for particular clients who choose to touch base with them.

A Metaphorical Analysis[5]

Ms. Koslowski continues to believe in a world where there is an ongoing battle between Good and Evil, where there is black magic that can be overcome by white magic. This world requires being on one's guard against forces of evil. People can become victimized. The hex became a manifestation of evil, attached to the fertile image of hair—attached yet external to the body. For eleven years, Ms. Koslowski engaged in a battle against the forces of evil and finally through prayer, the aid of a practitioner of white magic, supportive therapy, and the help of Catholic priests, she was able to end the hex. The hair is cut and buried. This is clearly a triumph of good over evil.

During the course of this battle, Ms. Koslowski's parents died. She lost the role of dutiful daughter supporting her immigrant parents. She emerged from the battle reinforced in her commitment to Good. She was able to move through the loss and is slowly taking on more independent roles. She continues contact with those who helped her through the late stages of the battle.

Implications for Stereotyped Service Delivery

The usual stereotype of how a state hospital delivers psychiatric services consists of patients receiving services and medication against their will, spending months on overcrowded wards, and being stripped of their beliefs and dignity. Ms. Koslowski received treatment in an outpatient clinic, was prescribed no psychotropic medication, and continues with her beliefs intact. What has changed is her own sense of herself. She has won a battle against Evil. She now has the power to withstand the forces of the Devil. She is on the verge of graduating from the mental health service system. What has kept her in the system until now are bureaucratic rules which state that in order to do the piecework at the sheltered workshop, she must be in active treatment.

Mental Health

Is Ms. Koslowski healthy? She is able to energetically cope with the world she faces. While her belief system might not withstand the rigors of scientific method, there are many throughout the world who frame their understanding in similar dimensions. She has found institutional reinforcement for maintaining this belief system, from her parish and from the mental health system. She is growing and changing, performing publicly as a singer, looking forward to joining the work force and leaving subsidies behind. Some would view her as eccentric because of the way she handles this battle. Some professional therapists would argue that success could come only when this belief system was wiped out to be replaced by one that they accept. Is there a reason to try and change this belief system? The belief system is not pathological. It forms the basis for her behavior. Not everyone in Ms. Koslowski's world is happy with her behavior; not the members of her immediate family nor her next door neighbor, the witch. If universal approval is the goal of mental health treatment, then most of us are in big trouble.

NOTES

1. All names in connection with this case have been changed to protect the confidentiality of the client.

2. Freedman, J.A., Cross cultural intervention: The case of the hexed hair. *Clinical Sociology Review, 6*, pp. 159-68.

3. Freedman, J.A., The case of the hexed hair revisted: A cross-cultural intervention one year later. *Clinical Sociology Review, 7*, pp. 172-74.

4. She used an insulting slur.

5. See Fein, M.L. (1990). *Role change: a resocialization perspective*. New York: Praeger.

Identification of Violence in Psychiatric Case Presentations

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ABSTRACT

Previous research on medical discourse suggests that physicians minimize patients' social problems through conversational and linguistic interactions. There has been little assessment, however, of the neglect of violence by psychiatric staff. In an attempt to address this important area, the case presentations of 77 recently violent psychiatric patients were examined. A contextual analysis of the violence mentioned during the case presentations revealed four categories of identification: violence as part of the primary problem, as a psychiatric disorder, as an unrelated incident, or not mentioned at all. In nearly two-thirds of the case presentations, the violence was not identified as part of the primary problem. The findings and case examples substantiate the assertion that social problems are neglected, minimized, or medicalized in medical discourse. They also suggest that clinical protocol should be established to ensure more extensive consideration of the "dangerousness" implied by reported violence.

The sociological study of medical discourse—that is, the discussion among physicians, clinicians, and patients—has become a rich and fruitful field in recent years (Kuipers, 1989; Mechanic, 1989). The broad perspective of this research has exposed the interactive processes by which medical conditions are defined and addressed. This research suggests how macrolevel

social structures are translated into microlevel personal experiences. For example, socially deviant behavior, like drinking excessive amounts of alcohol, may be redefined as a physical disease or psychological disorder through a physician's discussion with a patient (Conrad & Schneider, 1980).

The research on medical discourse has also stimulated critical assessment of the interaction among medical staff and patients (Kuipers, 1989; Mechanic, 1989). Physicians, according to several studies, systematically neglect or reframe social problems presented by patients as personal medical problems (Anspach, 1988; Mishler, 1984; Waitzkin, 1989). By social problems, we refer to dysfunctional, destructive, or disruptive behavior that is a manifestation of the social system or social structure of society. As a result, medical care often leaves patients subject to the worsening effects of untreated social problems and unprepared to deal with them.

The previous research on medical discourse generally described the medical response to social problems in one of two ways: Social problems tend to be either "medicalized" or "minimized." Medicalization refers to the tendency to identify a social problem as part of a medical problem (Conrad, 1975; Conrad & Schneider, 1980). For example, violent or criminal behavior might be interpreted as a manifestation of a psychosis. Minimization refers to the tendency to give a major social problem secondary or peripheral status to a medical problem (Anspach, 1988; Mishler, 1984). For example, medical staff might list a patient's attacks on his wife as merely one of several social circumstances such as poverty, unemployment, and homelessness.

How psychiatric staff discuss and evaluate the social problem of interpersonal violence has, however, not been substantially investigated. This topic is of particular interest because current violence is a primary factor in determining a patient's "dangerousness" (i.e., the likelihood of inflicting further harm on others), which is in turn a mandated criterion for involuntary commitment to a psychiatric hospital (Mulvey & Lidz, 1985). Psychiatric staff are in a position to identify potential violence and assist with intervention to interrupt or prevent it (Appelbaum, 1988). The Surgeon General has, in fact, designated interpersonal violence as a major health problem in America, and has prompted the medical profession to expand its role in reducing the level of violence nationwide (Koop, 1985).

This paper reports the results of a study examining an initial and fundamental step in addressing interpersonal violence: the identification of violence in psychiatric case presentations. We analyzed psychiatric case presentations to determine the nature and extent of psychiatric staff's actual mention of the violence which was reported by emergency room patients. An understanding of this violence identification process may not only fur-

ther sociological assertions about the nature of medical discourse, but also point to changes in clinical practice that can help to address and reduce violence.

The psychiatric case presentation by clinicians to psychiatrists seems a logical place to begin an investigation of the psychiatric response to violence. The case presentation is a pivotal point in the psychiatric evaluation process, conducted in a psychiatric emergency room or diagnostic center (Shea, 1988). During the case presentation, the clinician reports information to be used in determining the patient's diagnosis and disposition. The case presentation, in the majority of cases, is also the basis of the written case summary that becomes the official record of the patient. In short, the case presentation is where the patient's situation is formally defined.

In these presentations, clinicians (psychiatric nurses and staff psychologists) summarize information about a patient collected during their initial interviews with the patient. The psychiatrist (or psychiatrist-in-training) uses this information to guide both his or her brief interview with the patient and his or her eventual diagnosis and disposition of the case. The psychiatrist's interview is usually used primarily to substantiate or clarify the clinician's preliminary assessment which was summarized in the case presentation.

Research on Medical Discourse

Sociolinguistic analysis of medical discourse has become an increasingly popular means to assess the interactions among medical staff and patients. This approach has only recently been applied to the discussion of violence by psychiatric staff. Nevertheless, studies of physicians imply that psychiatric discussions tend to neglect reported violence. Mishler (1984), for instance, analyzed the interruptions during medical interviews to demonstrate how physicians control information and constrain patients' discussion of their "lifeworld." Physicians are shown to interject questions that redirect the patient's focus, whenever a patient begins to elaborate on a social problem or condition.

Anspach (1988) specifically assessed the case presentations in gynecological examinations as a "sociolinguistic ritual." Her analysis revealed a series of rhetorical devices used to reinforce physicians' medical decisions and minimize patients' social problems. Medical practitioners, for instance, use account markers, (e.g., "The patient reports..." or "The patient claims that..."), which emphasize the subjectivity of a patient's comments. They

also commonly use euphemistic or vague terminology, such as "marital conflict" to refer to extensive physical assault by a partner.

The emerging research on the discussion of violence in medical discourse has, however, generally focused on larger contextual markers. Several studies on physicians' discussion and reports about injured women in hospital emergency rooms show a more basic oversight: There is little mention or question about the possibility of an assault by a family member (Kurz, 1987; McLeer & Anwar, 1989; Warshaw, 1989). As few as 6% of the injured women in one emergency room were identified as "battered women," in contrast to nearly 30% who were identified as having been assaulted (McLeer & Anwar, 1989).

The communication patterns and structure of the case presentations themselves contribute to the neglect of violence. This line of research suggests that case presentations are part of the professional socialization process. Physicians tend to interrupt or correct clinicians until their presentations conform to a set procedure—namely, summarizing the pathology of the patient (Anspach, 1988; Arluke, 1978). Moreover, case presentations generally follow a prescribed structure that reflects the established diagnostic axes (i.e., clinical syndromes, personality disorders, physical disorders, psychosocial stressors, and global functioning) (Waitzkin, 1989). Social aspects of a patient's case are usually presented, if at all, only after medical problems have been discussed (Frader & Bosk, 1981).

In summary, the sociolinguistic research on medical discourse has revealed a variety of conversational and linguistic mechanisms that serve to minimize social problems. This research has not, however, offered a clear indication of how violence is identified in the first place. There is some indication that the identification of violence in case presentations is likely to reflect the expected diagnostic format or structure of these presentations. Reported violence, like other social problems, is most likely to be relegated to a social circumstance secondary to the patient's medical problem.

Method

Sampling

This study is based on data collected as part of a research project on the clinical management of dangerousness (see Mulvey & Lidz, 1985). Data were collected on 392 psychiatric patients who visited the emergency room of a metropolitan teaching hospital during a 6-month study period in 1985-1986. The psychiatric patients in this study represent a wide range of ethnic and

class backgrounds comparable to those in other urban psychiatric hospitals (Klassen & O'Connor, 1988; Segal, Watson, Goldfinder, & Averbuck, 1988). Researchers were present during the entire psychiatric evaluation process, including patient interviews and staff discussions. Using a form of shorthand, they took verbatim notes of the psychiatric discourse for each patient. These notes were later transcribed and used as the primary data base for this study.

A sample of 92 recently violent patients was identified from the transcripts of the evaluation interviews. Any patient who reported having assaulted another person (as defined by the Conflict Tactics Scale [Straus, 1979]) within the previous three months was considered "recently violent." This time frame was used to identify cases whose assaults were of most clinical concern. The majority of reported incidents which occurred more than three months prior to the interviews were lacking details and a specific time. A period of less than three months would have excluded assaults that had received clinical response and mention in clinical records. (For further discussion of the temporality, frequency, tactics, and targets of the reported violence, see Gondolf, Mulvey, & Lidz , 1989.)

Seventy-seven (84%) of the 92 recently violent cases were examined further in a qualitative analysis of the case presentations. Fifteen cases (16%) were deleted from the original sample (n=92) for one of the following reasons: 1) they did not include a case presentation; 2) only one staff person was available during the evaluation; or 3) the patient was sent directly to seclusion or to the ward without an evaluation interview. Therefore, the final sample of recently violent patients with case presentations numbered 77.

Case Presentations

The case presentations were assessed in terms of how clinicians presented the patients' report of violence to the attending psychiatrists. As mentioned in the introduction, we conducted a contextual analysis of the violence mentioned or alluded to in the case presentation. The categorization of the mentioned violence is grounded in the conventional format of the case presentation, and reflects the generalizations asserted in previous discourse research.

Case presentations follow a set format, according to training textbooks (Shea, 1988) and discourse studies (Waitzkin, 1989). The format is generally organized to deliver information on the five diagnostic axes used in evaluating psychiatric patients. Some statement about the primary problem or chief complaint usually begins the presentation, followed by psychiatric

symptoms and history, and social history and stressors. In an initial review of the cases, we found that clinicians presented incidents of violence as part of one of these three topics—or not at all.

Two researchers then reread the case presentations, categorizing the mention of violent incidents into four categories. These researchers, who were not involved in the initial data collection, categorized the mentioned violence with at an acceptable interrater agreement level (Kappa< 80). The four categories were as follows:

1) The violence was mentioned or referred to as part of the primary problem, generally at the beginning of the case presentation. The primary problem was defined as the main reason that the patient came to the emergency room.

2) The violence was mentioned later in the case presentation as a symptom or stressor related to a psychiatric disorder. The violence was reported with symptoms of psychosis, depression, or alcoholism.

3) The violence appeared toward the end of the case presentation, as part of a list of social circumstances apparently unrelated to the primary problem. The clinician at this point would summarize the patient's social history with brief mention of other social circumstances, such as, school behavior, employment, family status, living arrangements, and criminal activity.

4) The violence reported in the initial clinician-patient interview was not mentioned at all in the case presentation.

Representative case presentations are offered in the findings section below to illustrate the identification of violence in case presentations and the use of conversational and linguistic forms in this process.

Findings

Violence as a Primary Problem

Clinicians mentioned the reported violence as part of the primary problem in over a third of the cases (37%; n = 28 of 77). The patient, or someone accompanying him or her, initially reported this violence in the majority of these cases, as opposed to the violence being disclosed through questioning or tangential remarks. In these cases, the patient was likely to have a long history of violence and to apparently be "out of control." Moreover, the case presentations with violence as a primary problem generally provided more details about the violence than cases characterizing violence as a symptom or unrelated incident.

In one exceptional case, the clinician devoted the majority of her case presentation to elaborating the patient's violence, only to have the psychiatrist counter with questions about medical diagnosis. The clinician was obviously concerned about a 250-pound man's outbursts of violence. Her case presentation indicated that the patient had viciously attacked several family members for no apparent reason. She reported that the patient had punched his 65-year-old father in the face, knocking him to the floor, and threatened him with obscenities, until an older brother managed to restrain him.

The clinician began the staff discussion of the patient with the following case presentation:

Clinician: It's a 29-year-old, black, single male. He's 302'd (involuntary commitment) by his father. The patient complains that his father kicked him and his girlfriend out of his house. He punched his father, stood over him and cursed. A brother stopped any more from happening. There were no reported problems up to a year and a half ago. He does report five or six years ago being arrested on charges brought up by another girlfriend for statutory rape, burglary, and a number of other things. His current girlfriend and he lived in his parent's home for six months and things were okay. Then he physically abused her and they argued a lot. He says his parents threw them out. On his return home, he became increasingly violent. He sounds paranoid. Beginning in April he's been out of control. His dad had him arrested for hitting his brother with a pipe and smashing the minister's car window. The past few weeks he has increased in agitation.... The family is really scared of him; they don't want him back.

The psychiatrist responded to this case presentation with several questions about the patient's psychopathology: Does he take his medication? Is he a problem drinker? Any clear episode of manic activity? Any depressed episode? As the staff discussion proceeded, the clinician once again interjected her concerns about the violence:

Psychiatrist: The little I hear, it sounds like psychotic paranoid stuff.

Clinician: He is grandiose and psychotic.

Psychiatrist: We could call him paranoid schizophrenia.

Clinician: He's obsessed with his girlfriend. He probably attacked her.

Psychiatrist: He needs to be in the hospital for medication.

Clinician: The family doesn't want him back. They are scared.

Psychiatrist: We can commit him to one of the state hospitals. Well, I'll go say hello and welcome him to hospital life.

The clinician was obviously concerned about the patient's potential for unprovoked violence. Even when the attending psychiatrist turned the discussion to the psychiatric disorder or treatment ("We could call him para-

noid schizophrenia," and "He needs to be in the hosital for medication"), the clinician returned to issues related to the violence ("...He probably attacked her," and "...They are scared"). She later warned the psychiatrist to take precautions in the psychiatrist-patient interview, including contacting the security guards. The psychiatrist asked the patient eight or nine questions about his medication, announced that the patient was to be committed, and had the patient escorted to the assigned hospital unit. The psychiatrist, however, did not ever specifically acknowledge the violence, investigate it, or explicitly consider the safety concerns expressed by the clinician.

Violence as Symptom of a Psychiatric Disorder

Violence was presented as a symptom of a psychiatric disorder in approximately one-eighth (13%; n = 10 of 77) of the case presentations of recently violent patients. It was most commonly associated with chronic schizophrenia, alcoholism, or major depression. The clinician's presentation of the patient's violence generally occurred relatively early in the presentation, and was presented with other symptoms, such as hallucinations or suicide attempts. The description of violence in these cases tended to lack detail and to use vague terms to refer to the violence.

In one example, a woman came to the psychiatric emergency room and provoked a physical fight with another patient in the waiting area. While being interviewed by the clinician, the patient swore profusely and accused the staff of being "evil." The clinician alluded to this behavior at the outset of the case presentation, but implied that the patient's "abusiveness" was linked to the patient's disorder rather than being a primary problem.

Clinician: Ms. L. is an 18-year-old, white, single female. She just got out of Bellevue Hospital in New York. She is real abusive, very loose in associations, and real psychotic. The medicines that she is on now are Lithium, Navane, and Norpramin. She reports an overdose on Lithium; she won't say how many she took, just "a lot." She seems real angry and very irritable.

Psychiatrist: Do we know anything about her?

Clinician: Yes, she was admitted in July. She went to the ninth floor, then moved to the tenth. She was diagnosed as an atypical psychotic. She also suffers from some type of venereal wart. Apparently she went home after she was in New York , but experienced some type of problem with her father. She spoke with a lot of hostility during the interview. She did report that she would get suicidal again unless she got what she wanted.

Psychiatrist: Is she alone?

Clinician: No, she's with a boy called _____. She says that we can't talk to him because it's her right to keep her case private. Like I said, she is very agitated.

In the above example, the clinician's presentation indicated that the patient was abusive, but presented this as only one of several symptoms of psychosis. No details of the "abuse" were mentioned. Moreover, the clinician mentioned three times that the patient was hostile or agitated during the interview, but she did not mention that the patient had provoked a physical fight in the waiting area and had to be restrained by security staff. The clinician did, nevertheless, specifically recommend that the patient be involuntarily admitted to the psychiatric facility, and the psychiatrist agreed. This action was apparently taken because of the patient's psychosis rather than because of her violence.

Violence as an Unrelated Incident

In thirty percent (30%; n = 23 of 77) of the recently violent cases evaluated in the emergency room, clinicians presented the violence as unrelated to the primary problem. The violence was mentioned as part of a list of social or personal circumstances: "The patient has experienced long-term unemployment, lives on the street much of the time, and has a history of fighting." The reference to violence was again generally vague, rather than providing details of what was discussed in the clinician-patient interview.

The following example illustrates the identification of violence as an unrelated incident. An agitated patient visited the psychiatric emergency room because of a fight in his neighborhood. He reported ripping off the ear of his adversary, who was in the hospital at the time to have stitches for the injury. The patient explicitly stated during the clinician-patient interview that he was, as a result, very angry and thinking about retaliating in some way. The clinician specifically mentioned both the past incident and present hostility but with an account marker and without elaboration.

Clinician: This guy is Mr. R_____ who's a 23-year-old black, single male. He lives with his mom and dad. He wasn't on meds when he was here before. He's into heavy drugs and alcohol. He was in the emergency room about two months ago and his referral was to a private doctor. Previous diagnosis—substance abuse. He has been living on and off the streets; no job history to speak of. A history of physical problems. He

complained that he was angry and feeling out of control. He claims he hurt someone that he fought with.

Psychiatrist: So, anyway ...

Clinician: Anyway, this is what we've got.

Psychiatrist: Is this guy still in with his mom?

Clinician: Yeah, he said he had five days of sobriety but he's been smoking marijuana. He said he had two drinks tonight but I think he's had more. He has a history of five months of treatment at a county alcohol and drug treatment facility, and says that drugs and alcohol are not his problem. He says he's depressed. His symptoms include his being "evil," and he says that he "hates everybody" and that he "doesn't smile much." He says he has been unable to cry for seven years. He also said that, when he was in here before, he was not medicated for depression.

Psychiatrist: Does he have any other symptoms of depression?

Clinician: I didn't ask him about sleep and appetite. I didn't feel that there was a need at that point. He's telling me he's feeling violent and is thinking of beating up the other person.

Psychiatrist: Is he seeing a counselor?

Clinician: No. He was referred to outpatient treatment on August 13th. Somehow then he got referred to Dr._____. The patient says the doctor thinks he's a pervert and he's not a pervert, so he's not going to see him again.

Psychiatrist: I'm going to go ahead and see this guy.

In the above example, the presenting problem was the patient's violence. He was, in fact, brought to the emergency room because of a physical fight with a neighbor. The clinician's case presentation focused on the patient's polysubstance abuse and treatment, despite the patient's insistence that drugs and alcohol were not the problem. There was no inquiry about the circumstances or frequency of the violence, as might be expected in an assessment of dangerousness or lethality. The psychiatrist inquired about "other symptoms" in an apparent effort to obtain more information for a diagnosis.

The patient was admitted voluntarily to the psychiatric facility with the diagnosis of mixed substance abuse, and with no advisement regarding the patient's violence. The attending psychiatrist stated, in fact, that this patient did not really need to be admitted. The violence, by implication, was reduced to a secondary issue or circumstance.

Violence Not Mentioned

One last means of dealing with reported violence was not to mention it at all. The clinician did not mention the patient's violence during the case presentation in one-fifth (21%; n = 16 of 77) of the recently violent cases. The extent, type, or immediacy of the reported violence did not appear to influence the oversight. For example, there were at least three instances in which patients were assaultive in the waiting room and yet the incidents were still not mentioned.

In the following example, a patient was referred to the psychiatric emergency room by a psychiatrist. The patient told the clinician at the outset of the clinician-patient interview that he had been involved in several street fights and that was why the psychiatrist referred him to the emergency room. However, there was no reference to the violence in the case presentation.

Clinician: This is a very straight-forward case. Mr. F. is a 30-year-old, divorced male. He went to _____ University on a baseball scholarship and got his psychosis there. Apparently Prolixin does well for him. He showed up in the emergency room and has been started on Lithium.

Psychiatrist: Does he get bad to the point of seizures?

Clinician: No. He is very alert mentally. He can do all the problems we gave him. However, he does have some type of problem with his speech. Apparently he wants to play pro-ball. He does agree to come into the hospital. He is on SSI (Security Supplemental Income).

Psychiatrist: Oh, so all I really need to do is say "Hi."

Clinician: Yes, they know him up on the floor too.

Psychiatrist: You might want to send along to the floor some information about possible seizures. They may want to know what to do if he goes "goofy."

Clinician: OK.

Psychiatrist: OK, I'll see him.

In this case presentation, the clinician focused on the patient's pathology. He made no mention of the patient's violence, even though the violence was the main reason why the patient had been referred to the hospital. The subsequent staff discussion suggests that the staff believed that the patient's violence was a symptom of his seizures. Nevertheless, there was no specific elaboration of this point or of the potential danger his behavior posed for others. Yet, the patient's fighting was at least sufficient to have drawn the attention of the outpatient psychiatrist. The patient was admitted voluntarily to the hospital for further evaluation and medication.

Discussion

We reviewed the case presentations of 77 psychiatric patients who reported having committed an assault within the previous three months. In nearly two-thirds of these "recently violent" cases, the violent incidents were not presented as part of the primary problem. The violence was more often presented as a symptom of a psychiatric disorder (13% of the recently violent cases), as an unrelated incident (30% of the cases), or not mentioned at all (21%). Moreover, the urgency of the violence was obscured by account markers and vague terminology, agreeing with previous linguistic studies (Anspach, 1988). Overall, the clinicians focused on individual symptoms related to mental disorders rather than on social problems, such as violence.

In the case study of violence as a primary problem, the clinician's concern about the violence was made explicit throughout the case presentation. This case presentation may, in fact, be atypical in that the clinician deviated from the conventional evaluation structure to emphasize the patient's dangerousness. As in previous research on medical discourse, the psychiatrist used interruptions and questions to direct the case discussion back to symptomatology (Arluke, 1978).

These findings support the theoretical assertion that the medical orientation tends to obscure social problems either through medicalization or through minimization (Conrad & Schneider, 1980; Mishler, 1984). Our analysis suggests, in particular, that the medical structuring of case presentations relegates reported violence to a secondary priority or tangential descriptor, as Waitzkin (1989) has argued. In the process, a major criterion for involuntary commitment into a psychiatric facility may be slighted. Neglecting the reported violence may inadvertently condone the violence and allow it to continue, and even to escalate.

Our research suggests that a structural modification of case presentations could address this problem. Given the public safety and treatment issues involved, a clinical protocol for reported violence should be established. Clinicians might be required to present patient violence with the same thoroughness with which they usually present reported suicides. The circumstances, tactic, severity, target, temporality, and frequency of past violence might be routinely reviewed and assessed. Furthermore, referrals might be systematically made for both perpetrators and potential victims to appropriate human services programs, such as batterers' counseling or women's shelters. Potential victims might, additionally, be advised of appropriate protective services in the criminal justice system, such as "protection orders."

There are four methodological issues that should be weighed in future research on this important topic: 1) The clinicians' implied meanings and attending psychiatrists' unspoken interpretations of reported violence might be investigated. Perhaps psychiatric staff are implying serious concern regarding violence in the diagnoses they give. 2) The reported violence might be compared to verified accounts, since some of the reported violence may be delusional or exaggerated. The current studies on violence assess the mentioned violence at facevalue, whereas psychiatric staff may appear to neglect it because they doubt the patients' reports. 3) The relation of linguistic mechanisms used in minimizing violence to the categories of mentioned violence, derived in our study, might also be more systematically examined. Is the mention of "violence as an unrelated incident," for instance, structured in a consistent way? 4) Future research might also consider the disposition, treatment, and safety consequences of the medicalization, minimization, or neglect of violence in psychiatric case presentations. In other words, what is the actual impact of the practices noted in the current study?

At the very least, our contextual analysis indicates that the identification of violence in psychiatric case presentations warrants further sociological exploration. Our findings substantiate previous research on medical discourse that imply a neglect of patient social problems. Specifically, these findings raise concern about the clinical response to violent psychiatric patients. More needs to be done to insure that violence is sufficiently identified and assessed. This is especially the case given the increased threat to potential victims and jeopardy to public safety in general.

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Comparing the Psychological Impact of Battering, Marital Rape and Stranger Rape*

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ABSTRACT

This study compares the psychological impact of battering, marital rape, and stranger rape. Women who have experienced battering or marital rape as a form of battering are compared with victims of stranger rape victims in terms of their psychological functioning after victimization, as measured by the Derogatis Brief Symptom Inventory (BSI). The BSI measures somatization, obsessive-compulsive disorders, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The sexual functioning of victims is also compared. Overall, the marital rape victims scored higher on the BSI than victims of battering or stranger rape. Marital rape victims scored significantly higher than stranger rape victims on paranoid ideation and psychoticism.

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and significantly higher than battering victims on most dimensions The scores of victims of battering were similar to those of victims of stranger rape. Victims of marital rape and battering showed levels of sexual activity similar to victims of stranger rape, but significantly lower levels of sexual enjoyment. The findings are discussed from a sociological perspective concerning the relative impact of battering, marital rape and stranger rape.

Introduction

The study of the psychological impact of stranger rape has been a concern of clinical psychologists for some time (Burgess & Holstrom, 1974). Victims of stranger rape have been found to experience disruption of family relationships (especially when the victim is married), guilt, and self-blame, as well as the typical crisis reactions of crime victims such as changes in eating habits, disturbed sleep patterns, general problems with social interaction, and feelings of unattractiveness. (Scheryl & Sutherland, 1970; McCahill, Meyer & Fischman, 1979). Fear and anxiety have been shown to be common reactions to stranger rape (Kilpatrick, et al., 1979a, 1979b, 1988). Depression and somatic complaints have also been shown to be specific psychological reactions to stranger rape (Burgess & Holstrom, 1974; Kilpatrick, Veronen, & Resick, 1979a, 1979b; Ellis, Atkeson, & Calhoun, 1981).

Likewise, the study of the psychological reactions of marital rape victims has become a growing concern of family violence researchers (Finkelhor & Yllo 1985; Frieze, 1983; Hanneke & Shields, 1983; Russell 1984). Depression, humiliation, anger and somatic complaints (Finkelhor & Yllo, 1985), fear and anxiety (Russell, 1984), low self-esteem, dislike of men in general, and problems with sexual functioning (Finkelhor and Yllo, 1985; Shields & Hanneke, 1983) have all been found to be common in the aftermath of marital rape. As with battered women in general, guilt and self-blame are also characteristic reactions of marital rape victims (Finkelhor & Yllo, 1985). Resnik, et al. (1991) provide a recent review of research related to reactions of marital rape victims.

Although there appear to be similarities in the responses of marital rape and stranger rape victims, such as guilt and self-blame, fear and anxiety, negative feelings toward men, and depression and somatic complaints, there have been few attempts to systematically compare the relative impact of marital and stranger rape. In fact, the findings from the studies which have attempted such a comparison are unclear and inconsistent.

Bart's (1975) study of 1,070 responses to a magazine survey on rape found that victims of marital rape have more extreme psychological reac-

tions than victims of stranger rape. This study showed that women raped by husbands and lovers were much more likely to be sexually dysfunctional than those raped by dates and strangers. They were also more likely to have experienced a loss of self respect.

Several other studies have found that victims of marital rape seem to have the same psychological reactions as victims of stranger rape. Frank, Turner, and Stewart (1980) studied the immediate reactions of depression, fear, anxiety, and interpersonal functioning in 50 victims. They found that the victim's relationship to the perpetrator was unrelated to depression or social adjustment. Kilpatrick, et al. (1988) compared 391 marital, stranger, and date rape victims. They found that there were no differences in depression, obsessive-compulsive disorder, sexual dysfunction or social phobias among these three groups.

Koss, et al. (1988) administered a self-report questionnaire to 3,187 female students at 32 colleges and universities. The responses showed that 489 respondents had been rape victims, and that 44 had been raped by their husbands. The researchers assessed depression, anxiety, satisfaction with relationships and sexual satisfaction among the victims. They found that stranger and non-stranger rape victims did not differ in the types of psychological problems which they experienced. However, when victims of marital rape were compared with victims of acquaintance rape, differences emerged. Victims of marital rape rated themselves as more angry and depressed than victims of acquaintance rape. They also rated their assailants as more aggressive and saw themselves as less responsible for victimization. The findings also indicated that marital rape was often recurrent.

The variations in findings from these studies are complex and may be related to methodological issues. Some studies assessed long term effects, while others focused on immediate or intermediate reactions. Some of the studies placed primary emphasis on stranger rape, with the result that the samples of marital rape victims were very small. Most of the studies were highly empirical in nature, and did not provide a theoretical or conceptual basis for interpreting the results.

For example, from a psychological perspective one might argue that stranger rape will produce more serious psychological reactions in victims. Several cultural stereotypes concerning sexual intimacy support this prediction. Since, by definition, the perpetrator of stranger rape does not have an intimate sexual relationship with the victim, the victim may experience a more serious violation of physical privacy when raped by a stranger than when raped by a spouse or lover. The victim of stranger rape may have a greater fear of pregnancy, and if pregnancy does result, the social and psychological consequences may be more devastating. The victim may be

more fearful of how her victimization will affect her relationships with family and friends. If the rape becomes public, the victim may fear (perhaps accurately) that others will see her as responsible for her own victimization.

On the other hand, from a sociological perspective, there are reasons to predict that victims of marital rape will react more severely than victims of stranger rape. This prediction is rooted in the notion that people define their own identities in terms of on-going social relationships (McCall & Simmons, 1982). The marital relationship is particularly important in our society, since it functions as a "master status," which individuals use to organize and define their perceptions of others. For this reason, the act of marital rape is likely to have a dramatic impact on the relationship between the perpetrator and the victim. At the very least, it brings into question the victim's ability to trust her spouse, issues of power and dominance, and questions relating to the meaning of marital sex. Furthermore, the victim is likely to continue to face the perpetrator in daily interaction and to be subjected to recurrent, often brutal victimization (Black, 1979; Finkelhor & Yllo, 1985; Koss, et al., 1988).

Because of this on-going, socially and psychologically important relationship between the victim of marital rape and the perpetrator, we hypothesized that the experience of marital rape would produce psychological distress equal to or greater than that experienced by victims of stranger rape. We also predicted that the victim's ability to enjoy a sexual relationship would be more greatly affected by marital than by stranger rape.

Methods

The Marital Rape Sample

As part of a larger project on marital rape and battering, 142 standardized interviews were conducted by the authors with 44 "raped and battered" victims (women who had experienced both sexual and non-sexual violence), 48 "battered only" victims (women who had experienced non-sexual violence only), 45 non-victims (women who had experienced minimal or no levels of sexual or nonsexual violence) and 5 "marital rape only" victims (women who had experienced sexual violence only). The women were classified on the basis of very detailed questions concerning experiences with sexual and non-sexual violence. They were classified as victims of battering if they had experienced moderate or severe violence on two or

more occasions. They were classified as marital rape victims if they had experienced moderate or severe sexual violence on two or more occasions.

The classification procedures produced a sample of marital rape and battering victims who had experienced sexual and non-sexual violence in an ongoing, intimate, heterosexual relationship. Only sexual acts that were physically forced or were performed under threat of physical force were considered sexual violence. Because so few "raped only" victims were interviewed in spite of extensive case finding efforts (see Hanneke, Shields & McCall, 1986 for a discussion of the rarity of marital rape apart from battering), these cases were deleted from the statistical analyses, leaving a sample size of 137.

All respondents had lived with their partners for at least 6 months, and none had been separated from their partners for more than 3 years. Respondents were recruited from 14 different referral sources—local shelters for battered and homeless women (58); self help groups and programs (33); social service and public agencies, including court referrals of women who had filed for restraining orders (30); and advertising and "snowballing" (referrals from interviewees) (16). Approximately equal numbers of "battered only," "raped and battered," and non-victimized women were referred from each source, unless a particular group or agency did not serve a certain type of victim.

At the time of the interview, 29% of the women were living in shelters, 30% were still living with their partners, and 40% were living alone, with their children, or with other family members. Both types of victims were significantly more likely to be separated from their partners than the non-victims, and were more likely to be living in shelters. These are all factors that might produce higher stress levels for victims. Accordingly, relationships between reactions and type of victimization were examined, controlling for such factors as living arrangements, marital status, and current stress level (as measured by a scale developed by the researchers). Overall, although a few variables were found to be related to separation from the partner (independent of victimization), most psychological reactions were found to be unrelated to living arrangements or current stress level.

Of the 137 respondents interviewed, 56% (77) were white and 44% (60) were black. Respondents ranged in age from 17 to 63, and the average age was 31.4. Seventy-one percent (97) of the respondents were or had been married to their partners, and 29% (24) had cohabited. Respondents had been married or had cohabited for an average of 8.9 years, with a range from 6 months to 43 years. Only 30% (41) of the respondents had been

employed full-time during the last year of their relationship with their partner.

Educational levels ranged from 2 to 19 years of schooling, with a mean of 12.2 years. Type of victimization was unrelated to whether the respondent had been married or had cohabited, or to the victim's race, employment, or educational level. However, type of victimization was related to age and the length of the relationship. Non-victims generally cohabited or had been married longer, while the "raped and battered" victims were usually younger than either "battered only" victims or non-victims. However, there is some evidence that the relationship between age and victimization is spurious, and mainly due to the fact that younger women were being referred by the shelters, who also referred more "raped and battered" victims (see Hanneke, Shields & McCall, 1986).

Responses of the marital rape victims were compared with two studies of stranger rape victims. The first was a study of rape victims conducted in South Carolina (Kilpatrick, Resick, & Veronen, 1981). Twenty adult (age 16 or over) rape victims and twenty demographically matched non-victims were assessed at 1 month, 6 months, and 1 year post crime. Other than to note that there were no significant differences between victims and non-victims, demographic characteristics of the two samples were not reported.

A second study conducted in Atlanta provided an additional basis for comparison (Ellis, Calhoun, & Atkeson, 1981). In this study, victims of stranger rape were asked about sexual functioning 4, 16, and 48 weeks post crime. The sample consisted of 101 rape victims, 15 years of age or older. Most were in their late teens and twenties, lived in an urban area, were single or divorced, and were black. Respondents were equally distributed across middle class, lower- middle class, and lower class socioeconomic levels. One hundred and one women were assessed at 4 weeks post crime, 95 were assessed at 16 weeks post crime, and 66 were assessed at 48 weeks post crime.

Results

Derogatis Brief Symptom Inventory (BSI)

The BSI has been used by stranger rape researchers to measure depression and somatic disorders. It was chosen for use in this study because of the availability of published norms and the possibility of comparing the scores of marital rape victims with the scores of stranger rape victims. We

anticipated that the "raped and battered" group would exhibit the highest levels of depression and somatic complaints, followed by the "battered only" group, and that non-victims would exhibit the lowest levels of depression and somatic complaints. We expected that the scores of the comparison group would approximate a "normal" population. We also anticipated that the "raped and battered" group would score as high or higher than the stranger rape victims. There was no expectation about how the "battered only" victims would score in relation to stranger rape victims.

The BSI consists of 53 items designed to measure the psychological symptom patterns of individuals on 9 primary symptom dimensions, including physical somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (Derogatis & Spencer, 1982). There are also three global indices (2 of which will be discussed) which are helpful in the overall assessment of an individual's psychological status. The BSI is the brief form of the SCL-90-R and measures the same 9 dimensions and global indices (Derogatis & Spencer, 1982). Responses of the marital rape study respondents were compared with the norms for the BSI scale, as well as with the responses of rape victims and non-victims from the South Carolina study (Kilpatrick, et al. 1981). Because the norms for the BSI scale and the results from the comparison study are reported in different forms, each comparison will be discussed separately.

Comparisons with the BSI Norm Group

The BSI norm group consists of 341 female non-patients who were considered normal by the developers of the scale (Derogatis & Spencer, 1982). The total normal sample consisted of 974 non-patient males and females, of which 86% were white, 14% were minorities and the mean age was 46. In order to compare the marital rape study respondents with the norm group, the group raw mean scores were converted to standardized T-scores based on the conversion tables for female non-patients. Table 1 shows the standardized scores for all 9 symptom dimensions, and the two global scores of interest.

The first symptom dimension listed in table 1 is "Somatization," which consists of 7 items reflecting distress from perceptions of bodily functions (e.g., faintness, dizziness, nausea, or upset stomach). The scores for this dimension ranged from 57 to 63 with the "raped and battered" group scoring the highest, and the non-victims the lowest.

Table 1. Standardized T-Scores on the SCL-53 for Marital Rape Study Respondents

	Standardized T-Scores		
	Nonvictims	Battered Only	Raped and Battered
1. Somatization	57	61	63
2. Obsessive/Compulsive	59	64	67
3. Interpersonal Sensitivity	57	64	67
4. Depression	60	64	68
5. Anxiety	59	66	68
6. Hostility	56	63	67
7. Phobic Anxiety	57	64	65
8. Paranoid Ideation	59	65	71
9. Psychoticism	63	66	75
10. GSI	59	66	71
11. PST	57	62	65
Group N's	45	48	44

The "Obsessive-Compulsive" dimension consists of 6 items, which include thoughts, impulses and actions which are unwanted by the individual but are experienced as unremitting and compelling (e.g., having to check and double check actions, having one's mind go blank). Again, the "raped and battered" group scored the highest, with a 67, and the non-victims scored the lowest, with a 59.

The third dimension of the BSI measures "Interpersonal Sensitivity" and consists of 4 items centering on feelings of personal inadequacy and inferiority in comparison with others (e.g., feeling very self conscious with others). The same pattern emerges on this dimension, with non-victims having fewer symptoms (a score of 57) than either the "battered only" group (64) or the "raped and battered" group (67).

The "Depression" dimension consists of 6 items indicative of clinical depression (e.g., feeling lonely, having no interest in things). The "raped and battered" group scored the highest on this dimension, with a score of 68, followed by the "battered only" group, with a score of 64, and the non-victims, with a score of 60.

The fifth dimension contains 6 symptoms and signs of anxiety (e. g., nervousness, feeling fearful, panic spells, suddenly feeling scared for no appar-

The fifth dimension contains 6 symptoms and signs of anxiety (e. g., nervousness, feeling fearful, panic spells, suddenly feeling scared for no apparent reason, restlessness, and feeling tense or "keyed up"). Again, the "raped and battered" group, with a score of 68, exhibited higher levels of anxiety than either the "battered only" group (66) or the non-victims (59).

The "Hostility" dimension contains 5 items that reflect thoughts, feelings, or actions that are characteristic of anger (e.g., uncontrollable temper outbursts, and frequent arguments). The non-victims appear to be the least hostile of the three groups, with a score of 56, the "raped and battered" group (67) appear to be the most hostile, and the "battered only" group (63) scored between the other two groups.

The seventh dimension, "Phobic Anxiety," consists of 5 items designed to measure fear responses to specific people, places, objects or situations which are persistent, irrational and lead to avoidance (e.g., feeling afraid in open spaces or in the street). The "raped and battered" group (65) was the most phobic, followed by the "battered only" group (64), and finally by the non-victims (57).

"Paranoid Ideation" consists of 5 symptoms representing a disordered mode of thinking (e.g., feeling others can't be trusted, feeling watched or talked about by others, not receiving credit for your achievements, feeling others are taking advantage of you, or feeling others are to blame for most of your troubles). The raped and battered" group exhibited the highest levels of paranoid ideation, with a score of 71, followed by the "battered only" group (65) and the non-victims (59).

The final dimension, "Psychoticism," consists of 5 symptoms indicative of interpersonal alienation and psychosis (e. g. feeling something is wrong with your mind, feeling that someone else can control your thoughts, feeling lonely when with others, feeling that you should be punished, or never feeling close to another person). Again, the "raped and battered" group scored the highest, with a score of 75, followed by the "battered only" group (66) and the non-victims (63).

The two global measures of interest are the General Severity Index (GSI) and the Positive Symptom Total (PST). The GSI is the mean score of all 53 items. The PST is the number of items responded to positively (i.e., an indication of having experienced the symptom at any level). As Table 1 indicates, the "raped and battered" group scored higher than either of the other groups on both the GSI (71) and the PST (65), followed by the "battered only" group (66 and 62), with the non-victims exhibiting the lowest levels (59 and 57).

To determine if a particular score indicated that the individual had a psychological problem, an operational definition was devised by Derogatis and

Spencer (1982). According to this definition, a GSI score equal to or greater than 63 was indicative of a positive diagnosis. Both the "raped and battered" and the "battered only" groups scored over the cut off point, and therefore appeared to be experiencing psychological distress. The non-victims as a group scored below the cut off. Examining the individual dimensions, the "raped and battered" group scored at or above the cut off point on all 9 dimensions, and the "battered only" group scored at or above the cut off point on every dimension except "Somatization" and the PST. The non-victims scored at 63 on only one dimension, psychoticism. In summary, the results indicate that in comparison with female non-patient normals, "raped and battered" victims suffered extreme psychological distress in all nine areas, "battered only" victims suffered extreme distress in 8 areas, and non-victims were, for the most part, free of psychological distress except in the area of psychoticism. Overall, the non-victims were very similar to the normal population.

Comparison of the BSI with Stranger Rape Victims

Besides the norms for the BSI, comparisons were also made with victims and non-victims from the South Carolina study. This study used the SCL-90-R, but because both versions of the scale were so highly correlated, the subscales could be compared (Derogatis & Spencer, 1982). The scores on the PST were impossible to compare across studies because the scores were based on the total number of positive responses, and therefore the scores were not comparable. Kilpatrick, et al. (1981) reported their results as raw mean scores for victim and non-victim groups, and therefore scores from the marital rape study will be reported in the same way. Ninety percent of the victims in the marital rape study had experienced some form of violence in the year prior to the interview. Since the exact length of time since victimization was unknown, 6 months was chosen as the comparison point for the South Carolina study. Table 2 presents the mean scores of the SCL-53 and SCL-90-R for participants in the respective studies.

First, analysis of variance was performed on the marital rape study data to identify significant group differences for that study. When significant overall differences were identified, Duncan's Multiple Range Test was performed to identify significant contrasts. T-tests were computed to determine significant differences between the two studies.

On all dimensions of the BSI, marital rape study non-victims scored consistently lower than the "battered only" and the "raped and battered" groups. They scored significantly lower than both groups on all dimensions, including the GSI, except Somatization; on this subscale they were

Table 2. SCL-53 Mean Raw Scores and Standard Deviations for Marital Rape Victims (MR), Battered Only Victims (B), Rape Victims (RV), and Non-Victims (NV) Groups

	Marital Rape Study						Rape Study			
	NV		B		MR		NV		RV	
	MN	SD	MN	SD	MN	SD	MN	SD	MN	SD
1. Somatization[a]	49*	.59	.74	.79	1.01	.89	.50	.41	.80	.60
2. Obsessive-Compulsive[b]	.61*	.62	1.12	.97	1.50	.94	.56*	.50	1.07	.81
3. Interpersonal Sensitivity[b]	.67*	.73	1.05	1.10	1.63	1.04	.57*	.55	1.21	1.05
4. Depression[b]	.67*	.78	1.24	1.10	1.60	1.03	.69*	.68	1.32	.99
5. Anxiety++	.69*	.74	1.41	1.17	1.72	1.05	.45*	.56	1.19	.92
6. Hostility[b]	.44*	.48	.85	.97	1.22	1.07	.50	.48	.83	.73
7. Phobic Anxiety	.34*	.57	.72	.97	.98	.98	.19*	.29	.94	.88
8. Paranoid Ideation+[b]	.68*	.72	1.18	1.11	1.69	.93	.55*	.63	1.16	.93
9. Psychoticism+[b]	.47*	.58	.86	.82	1.41	.98	.36*	.47	.76	.77
10. GSI[b]	.57*	.52	1.03	.82	1.4	1.81	.52*	.46	1.07	.76
Group N's	45		48		44		20		20	

*T-test shows significant differences between Non-Victim Group and any Victim Group at .05 or beyond.

+T-test shows marital rape group is significantly different from the relevant rape study comparison group at .05 or beyond

(non-victims are compared with non-victims and victims are compared with victims).

++Indicates significance at .10 level or beyond.

[a]=Raped and battered group is significantly different from battered only group at .05 or beyond.

[b]=All three marital rape groups significantly different from one another at .05 or beyond.

not significantly lower than the "raped and battered" group. Generally, their scores were quite similar to the stranger rape study non-victims, and on several subscales they were almost identical (Somatization, Depression, and the GSI). Stranger rape study non-victims scored significantly lower than victims on all dimensions of the BSI except Somatization and Hostility.

The "battered only" group scored significantly lower than the "raped and battered" group on most dimensions of the BSI, including Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Hostility, Paranoid Ideation, and Psychoticism, as well as the GSI. There were no significant differences for Anxiety and Phobic Anxiety. Overall, the scores of the "battered only" group resembled the scores of the stranger rape victims. However, their scores on Interpersonal Sensitivity were somewhat lower (B=1.05; RV=1.21) and on Anxiety were significantly higher (B=1.41; RV=1.19) than those of the stranger rape victims.

Victims of marital rape scored consistently higher than stranger rape victims on all dimensions of the BSI, except Phobic Anxiety. On this subscale, their scores were almost identical (MR= .98; RV= .94). Marital rape victims scored significantly higher than stranger rape victims at or above the .05 level on the dimensions of Paranoid Ideation (MR= 1.69; RV= 1.16) and Psychoticism (MR= 1.41; RV= .76). They were significantly higher on Anxiety at a .10 level (MR= 1.72; RV= 1.19).

In general, it appears that marital rape in the presence of battering produces higher levels of psychological distress than does battering alone. Further, marital rape appears to produce levels of distress equal to or greater than those caused by stranger rape. Victims of battering score at levels similar to those of stranger rape victims. This suggests that battering may be as psychologically traumatic as stranger rape. The combination of marital rape and battering produce significantly higher levels of Paranoid Ideation and Psychoticism, and to a lesser extent, Anxiety than either battering alone or stranger rape.

Compared with the norms, all victim groups experienced problematic psychological distress. The non-victims of either study did not experience abnormally high distress compared with the norms.

Sexual Functioning Assessment

In order to determine if sexual and non-sexual violence have an effect on sexual functioning, respondents were questioned about their sexual behavior and sexual functioning in the year prior to the interview. Again, it was anticipated that the marital rape victims would have experienced

tims or the non-victims, and at least as many problems as the stranger rape victims.

Responses of the marital rape victims were compared with the responses of stranger rape victims from the Atlanta study (Ellis, et al. 1981). Since marital rape study respondents were only asked about sexual functioning during the last year, comparisons with stranger rape victims were made at 48 weeks post crime. Table 3 presents the distribution of responses to the three questions that were compared.

The first question asked, "How often have you had sex lately (in the past year)?" Thirty-eight percent of the stranger rape victims were having sex twice a week or more, which was comparable to the non-victims in the marital rape study. Analysis of variance of the group means in the marital rape study indicated that there were no statistically significant differences between the three groups in frequency of intercourse. However, approximately 48% of each group of the marital rape study victims were having sex twice a week or more, which was a higher percentage than among either the marital rape study non-victims or the stranger rape victims.

Table 3 also indicates that 23% of the stranger rape victims were not having sex at all at 48 weeks post crime. However, this figure is somewhat misleading. Ellis, Calhoun, and Atkeson (1981) indicate that 14% of the victims in their study were not sexually active before the rape experience. Thus, the 23% figure represents only about 9% of "once sexually active" women who were no longer sexually active after the rape experience. This is only slightly higher than the 6-7% of any group in the marital rape study who indicated that they had not been sexually active in the past year. A T-test comparing victims of marital rape and battering and victims of stranger rape showed no significant differences between these two groups.

The remaining two questions pertained only to those women who had been sexually active "lately" or "in the past year." This reduced the number of respondents in the stranger rape study to 51, and in the marital rape study to 124. In the Ellis study, the women who had not been sexually active were included in the percentages given. For current purposes, these cases have been subtracted out of the sample to make comparisons with the marital rape study more straightforward.

The second question asked, "How much of the time have you enjoyed sex lately (in the past year)?" Table 3 indicates that 59% of the stranger rape victims had enjoyed sex "most of the time." This percentage was much higher than the 31% of "raped and battered" women, and the 44% of "battered only" victims who enjoyed sex most of the time. The marital rape study non-victims were the most likely of all groups to indicate that they

Table 3. Responses of Stranger Rape and Marital Rape Study Respondents to Sexual Functioning Questions

	MARITAL RAPE STUDY GROUP PERCENTAGES			GROUP MEANS			STRANGER RAPE STUDY (48 WEEKS POST-CRIME) GROUP PERCENTAGES
	NV	B	RB	NV	B	RB	V
1.How often have you had sexual intercourse lately (in past year)?							
2/week or more	37.8%	47.9%	47.7%	3.91	3.79	3.95	38.0%
2-4 times a month	35.6	18.8	20.5	higher score=greater frequency			30.0
once a month/rarely	20.0	27.1	25.0				9.0
not at all	6.7	6.3	6.8				23.0
Group N's	45	48	44				66
2.If sexually active, how much of the time did you enjoy sex (in past year)?[a,b]							
most of the time	65.9%	43.9%	31.0%	4.46	4.10	3.64	59.0%
about half the time	14.6	24.4	19.0	higher score=more enjoyment			20.0
occasionally	19.5	29.3	38.1				14.0
never	0.0	2.4	11.9				8.0
Group N's	41	41	42				51
3.If sexually active, how much of the time have you been orgasmic (in past year)[c]							
most of the time	51.2%	34.1%	26.2%	4.24	3.83	3.69	43.0%
about half the time	24.4	22.0	26.2	higher score=more enjoyment			16.0
occasionally	22.0	36.6	38.1				22.0
never	2.4	7.3	9.5				18.0
Group N's	41	41	42				51

[a]=ANOVA p<.05 all three groups significantly different from one another (significant differences only indicated for differences between Non-Victim Group and any Victim Group)
[b]=T-test p<.01 (raped and battered group significantly different from stranger rape group) (non-victims significantly different from victims)
[c]=T-test p<.05 (non-victims significantly different from victims)

enjoyed sex most of the time, and none of the non-victims indicated that they never enjoyed sex.

Examination of the group means indicates that all three marital rape study groups were significantly different from one another. Almost 12% of the "raped and battered" victims said they never enjoyed sex, as compared to 2.4% of the "battered only" victims, and 8% of the stranger rape victims. The majority of the stranger rape victims enjoyed sex most of the time, as did the non-victims and the "battered only" victims, whereas the majority of the "raped and battered" women enjoyed sex only occasionally. A T-test revealed that the stranger rape victims were significantly more likely than the "raped and battered" victims to enjoy sex.

The third question asked, "How much of the time (in the past year) were you orgasmic during sex with a partner (by whatever means)?" Forty-three percent of the stranger rape victims indicated that they were orgasmic most of the time, whereas only 26.2% of the "raped and battered" group and 34% of the "battered only" group were orgasmic most of the time. The non-victims were the most likely of all three groups to be orgasmic most of the time (51.2%). Analysis of group means indicates that the non-victims were significantly more orgasmic in the last year than either victim group. Only 2.4% of the non-victims were never orgasmic, followed by 7.3% of the "battered only" victims and 9.5% of the "raped and battered" victims. The stranger rape victims were the most likely never to be orgasmic (18%). However, the non-victims in the marital rape study were the most likely to be orgasmic most of the time, followed by the stranger rape victims. The majority of the "raped and battered" victims and the "battered only" victims were orgasmic only occasionally. The "raped and battered" group was not significantly different from the stranger rape victim group.

In general then, the type of victimization does not seem to predict the frequency of intercourse following victimization. However, there does seem to be a tendency for marital rape to affect how much the victim enjoys sex following victimization. Stranger rape victims were significantly more likely than "raped and battered" victims to enjoy sex. At 48 weeks post crime, the stranger rape victims enjoyed sex more often than the "battered only" victims, but not as much as the non-victims.

The relationship between violence and being orgasmic during sex is more complicated. It appears that for stranger rape victims, many are orgasmic again most of the time at 48 weeks post crime. However, as a group, they are almost twice as likely as marital rape victims never to be orgasmic. It appears that marital rape and battering combined, and battering alone make it less likely that a woman will be orgasmic as compared to non-victims. However, victims of marital rape and battering were not

significantly less likely than victims of stranger rape to be orgasmic, even though there was a clear tendency for them to be orgasmic most of the time, but on less frequent occasions.

Discussion

This study sought to assess differences in the psychological impact of battering, marital rape, and stranger rape, as measured by the Derogatis Brief Symptom Inventory and by questions regarding sexual functioning. Although comparisons between the victims of battering and marital rape are more straightforward, the differences which were found between the marital rape study and the stranger rape studies need to be interpreted with caution.

There are notable demographic differences between the samples. The respondents who participated in the marital rape study tended to be older, married and more frequently white than those studied by Ellis. Ruch and Chandler's (1983) findings may be relevant here. They found that older, married rape victims were the most highly traumatized, but non-white women were also highly traumatized. Since demographic characteristics were not reported in detail for the Kilpatrick study, it is difficult to determine differences in demographics with other studies. In addition, the sample size in the Kilpatrick study was quite small. However, although these differences need to be interpreted cautiously, the fact that non-victim scores from the stranger and marital rape studies were so similar on the BSI argues that the observed effects might well be due to actual variation in impact as a result of type of victimization, rather than to demographic characteristics alone.

The comparisons of the marital rape and battering victims on the BSI with a normal population clearly showed the psychological impairment of both groups of victims. The "raped and battered" group scores were particularly elevated in the Paranoid Ideation and Psychoticism subscales. When looking at the marital rape study groups, a clear progression of impact from victims of battering only to victims of both marital rape and battering can be seen. This pattern was most evident on the dimensions of Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Hostility, Paranoid Ideation, and Psychoticism, as well as on the General Severity Index. The data strongly suggest that marital rape has an impact above and beyond that of battering alone.

Overall, the "battered only" victims appear to be quite similar to victims of stranger rape in their psychological responses. This finding is interest-

ing in that different forms of violent victimization (sexual and non-sexual) produced a similar impact. Further research is needed on the ways in which sexual and non-sexual violent victimization is perceived by victims, in order to better understand the similarity of psychological impact.

The victims of marital rape experienced psychological distress equal to or greater than that experienced by stranger rape victims on all subscales. Although not statistically significant, there was a tendency for victims of marital rape to score higher on all the subscales except phobic anxiety, where they obtained scores almost identical to victims of stranger rape. This finding is also interesting, in that previous research on stranger rape victims has identified a marked tendency for these victims to react with phobic anxiety (Kilpatrick, et al. 1979a, 1979b). Relative to victims of marital rape and battering, phobic anxiety seems to be a particularly severe response in stranger rape victims.

The marital rape victim scores exceeded the stranger rape victim scores on Psychoticism and Paranoid Ideation at a statistically significant level. This is important in that these two subscales contain items that are directly related to the quality of one's intimate relationships. The Paranoid Ideation scale deals with an individual's inability to trust others, and their tendency to feel taken advantage of by others. The Psychoticism subscale contains items having to do with feeling one's thoughts are controlled by others and never feeling close to another person. During interviews, many victims of marital rape and battering spoke informally of feeling "controlled" by their partners. These findings are consistent with the sociological hypothesis that the greater psychological impact of marital rape has to do with the destruction of the marital relationship as well as with the violence itself.

The findings on sexual functioning also highlight the need to interpret the psychological functioning of victims in terms of their ongoing social relationships. Although the difference was not statistically significant, marital rape victims and battering victims had sexual intercourse more frequently than stranger rape victims in the year prior to the interview. Since many of the marital rape study victims were still continuing relationships with the perpetrator, this may indicate that norms regarding the frequency of intercourse in the relationship are maintained, regardless of victimization. However, stranger rape victims exhibited much higher levels of enjoyment of sexual intercourse than victims of battering or marital rape. Again, this may be due to the fact that many of the marital rape and battering victims were continuing relationships with the perpetrator. For those who had ended their relationships, the findings may indicate that victimization in an intimate relationship, especially sexual, reduces the chances of enjoyment in future sexual relationships. Although not statistically sig-

nificant, the same pattern was evident regarding the victim's ability to be orgasmic during sexual activity.

In conclusion, the findings from this study argue for more comparative work on the victimization of women in general. Due to the small number of respondents who were victims of marital rape only, we were unable to compare this group with victims of stranger rape. This is an obvious limitation of the present study, and a topic which might be pursued in future research. The findings also argue that a sociological perspective on psychological reactions of victims may be a fruitful approach for clinicians in the treatment of victims of sexual and non-sexual violence.

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Sudden Infant Death Syndrome and the Stress-Buffer Model of Social Support

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ABSTRACT

This study examines the effect of social support on the adverse effects of Sudden Infant Death Syndrome stress. The effect of participation in the Sudden Infant Death Syndrome support group on the facilitation of the grief process is also examined. The data for this study were collected from personal interviews with 31 SIDS parents. The data are analyzed within a stress-buffer model of social support.

Social support research has become increasingly popular in recent decades. Although research into the importance of social ties can be found in the works of Durkheim (1897) nearly a century ago, it is only recently that the body of literature in this area has grown substantially.

In the 1970s, research by Cassel, Caplan, and Cobb laid much of the foundation for social support (Vaux, 1988). Cassel (1974) stated that stress and support often intertwine and disrupt social ties, as in the case of loss, grief, and bereavement. Caplan (1974) stressed the importance of support systems in protecting the individual's well-being in situational crises. Cobb's (1976) major emphasis was on social support as a stress buffer. He

concluded that adequate social support can protect people undergoing crises from physical and psychological disorders. These researchers established the issue that has dominated the field ever since—that social support acts as buffer against the adverse effects of stress.

Sudden Infant Death Syndrome (SIDS), the sudden and unexpected death of an 'apparently healthy' infant, results in considerable disruption and stress to the lives of young couples, who commonly have had only limited experience in coping with death, bereavement, and grief. In spite of the fact that the etiology of Sudden Infant Death Syndrome is unknown and that deaths cannot be predicted, intense feelings of guilt are common (Stillon, 1985). Grief, guilt, and a lack of knowledge about SIDS, in conjunction, become a major emotional stress for parents, both as individuals and as a couple (Weinstein, 1978). For a variety of reasons, such as the sudden and unexpected nature of the death itself, the aftermath of a SIDS death may be more traumatic and problematic than that precipitated by other deaths (Markusen, 1978).

Due to the traumatic effect of Sudden Infant Death Syndrome on the family, the SIDS Agency provides immediate grief support and counseling to all families. The support offered to families assumes the form of providing them with unconditional emotional support at the time of the death, providing them with accurate information about SIDS, and inviting them to join and participate in the SIDS support group.

Statement of the Problem

This study examines the effect of social support on the SIDS grief process and the effectiveness of SIDS' support group meetings and counseling in facilitating parents' grief. Given the social support literature, this study hypothesizes that those parents who have adequate social support systems available will experience a decrease in the adverse effects associated with Sudden Infant Death Syndrome stress, as compared with those parents who have little or no social support systems available. This study also hypothesizes that participation in the SIDS support group meetings will facilitate the SIDS grief process. The stress-buffer model of social support, which postulates that social support acts to protect individuals from the effects of stressful conditions, will be used as the theoretical tool of analysis in this study.

Theoretical Orientation

Social support has been defined in the literature as consisting of two components—social and support. The social component reflects the individual's ties to the social environment. These are represented at three levels: the community, the social network, and the intimate/confiding relationships. The support component reflects instrumental and expressive activities. Reflecting these two components, Lin, Dean, and Ensel (1986) defined social support as "perceived or actual instrumental and/or expressive provisions supplied by community social networks and intimate relationships."

It has also been proposed that social support might be perceived as knowledge or information given to an individual that leads that person to feel he/she belongs and is loved and valued. Given this criterion, social support should function not only to fulfill a person's needs, but also to protect him/her from the negative effects of stress and crises (Cobb, 1976). Other researchers have formulated definitions of social support that include at least one of the following factors: affect, affirmation, and aid (Barrera, 1981; Gottlieb, 1978; Weiss, 1974; Vaux, 1982).

Studies have concluded that social support which meets individuals' basic needs (approval, esteem, self-worth) plays a key role in alleviating stress-related disorders (Cassel, 1974). Other research studies have demonstrated that intimate relationships not only further well-being, but shield individuals from the adverse effects of stress (Lownethal & Haven, 1968; Medalie & Goldbourt, 1976; Miller & Ingham, 1976). Barrera (1981) noted that supportive behavior seems to serve as a barometer of the amount of stress experienced. Wilcox (1981) conducted a study of life stressors, social support, and distress among adult residents and concluded that individuals who have adequate social support are protected from the adverse consequences of stress. Lin (1986) reported that the negative effect of life stressors on distress is reduced by social support. Lin, Dean, and Ensel (1986) postulated that "access to and use of strong and homophilious ties promotes mental health."

Although there is convincing evidence that social support can buffer the effects of stressors, there are also some studies which did not yield support for the stress-buffer model (Fischer, 1985; Ganster, Fusilier, & Mayes, 1986; Monroe, Bromet, Connell, & Steiner, 1986; Norbeck, 1985; O'Neill, Lances & Freemon 1986; Solomon, 1985; Sykes & Eden, 1985; Turner & Wood 1985). In comparing those studies which supported the stress-buffer model of social support and those studies which did not, it is observed that the buffer effect is present only under certain conditions. Vaux (1988, p.

120) offered the following explanation for the differential findings: "In sum, evidence for the buffer model is not conclusive, but it is evident in studies employing life event stressors, psychological distress outcomes and appraisal measures of support." Mitchell, Billing, & Moos, (1982) reported that social support does not buffer all stressors equally. Stressors differ in magnitude of loss incurred, readjustment required, and the degree to which stressors may be controlled (Vaux, 1988).

Further, studies have demonstrated that certain stressors, such as illness and tragic loss, may temporarily incapacitate supportive relationships. These stressors may involve issues so tragic that an otherwise supportive network member may simply not be able to deal with them (Gore, 1984; Thoits, 1982). This finding is particularly relevant to Sudden Infant Death Syndrome research, since often the sudden, unexpected loss of an 'apparently healthy' infant is one of these tragic events that can render supportive network members incapable of providing support.

Although past stress-buffer model studies of social support have yielded mixed findings, this research study examines a life event stressor (sudden death) which past studies have found to be a condition under which social support acts as a buffer against the adverse effects of stress. Therefore, despite the inconsistent findings of past social support studies with respect to the stress-buffer model, this research study expects to yield support for the model.

Research Design

Data to test the research hypotheses were collected through questionnaires and interviews. The sample for this study was not random since the questionnaires and letters requesting interviews were mailed only to those SIDS parents with whom the New Mexico Sudden Infant Death Syndrome Agency had maintained contact during the ten years since its inception (1976-1986). Those parents with whom the agency had not maintained contact were typically parents who had relocated, often to another state, and had not given the agency any forwarding address. The questionnaires and letters requesting interviews were mailed to 210 parents. Sixty-three (30%) of the questionnaires were returned and thirty-one (15%) parents consented to interviews. Some parents who chose not to participate in this study stated that the death (often quite recent) of their child was still too painful to discuss. For other parents, however, the death had occurred several years prior and they did not wish to "relive" this difficult emotional experience.

These data were gathered with the objective of utilizing both qualitative and quantitative data, to yield a more complete understanding of the effect of social support on stress. However, after analyzing the quantitative data, which measured changes in parents' emotions, behaviors and relationships after a SIDS death, it was apparent that these data were not significant or informative. For instance, when the responses of those parents who stated that they had social support systems available to them after the SIDS deaths were compared to the responses of those parents who stated they did not have support systems available, no statistically significant differences were revealed. This was also the case when the responses of the participants of the SIDS support group were compared with the responses of non-participant parents. One reason that statistical significance was not revealed was that the number of questionnaire respondents was so small.

The interviews, however, revealed much more in-depth, rich, and informative data. The responses of the parents to interview questions were more helpful to an understanding of the effect of social support system availabilty on life event stressors than the statistics generated by the questionnaires. Consequently, this study will utilize only the qualitative data in examining the effect of social support on the SIDS grief process and the effectiveness of SIDS' Agency support group in facilitating parents' grief.

Data Analysis

Analysis of the qualitative data revealed that of the 31 individuals who consented to an interview, 24 were female and only 7 were male. This was not an unexpected finding, since the literature has frequently documented the greater willingness of women to share personal life experiences (Kalish, 1985). From childhood, women develop friendships by sharing serets, emotions, hopes, and fears. Intimacy is a crucial part of friendship for them. Women often explore, discuss, and analyze topics at length, and in depth. Men, however, are usually more comfortable discussing numerous topics, and spending only a short amount of time on each (Tannen, 1990). As a result of these communication differences, it is not surprising that more women than men consented to an interview which entailed discussing the emotional, behavioral, and relationship changes following the death of their infant.

These communication difference also affect the benefit which parents derive from participation in the SIDS support group. The interviews revealed that, although all the parents who attended the SIDS support group meetings reported them beneficial in coping with the behavioral changes

and the stress which followed a SIDS death, women seemed to derive greater benefit then men. One father interviewed provided insight into why women benefit more from the support group than men. Although he participated in the meetings and found it therapeutic to listen to others' experience, he often found it difficult to share his experiences. One reason that he offered for this was that he had never felt comfortable revealing his emotions. However, a more important reason was that the group, at the time, contained only one man. The fact that SIDS groups, and counseling groups in general, normally have more female members than male may contribute not only to men's difficulty expressing themselves in these groups, but also to their reluctance in joining them.

SIDS Support Group and the Facilitation of the Grief Process

The interviews revealed that the grief counseling and support provided to parents in the SIDS support group meetings were beneficial because these meetings resulted in parents attaining a better understanding of SIDS and the normal grief process associated with it. All parents were provided with written information (brochures, pamphlets, etc.) concerning Sudden Infant Death Syndrome (the incidence rates, the current state of SIDS knowledge, SIDS risk factors, etc.) and the grief process associated with Sudden Infant Death Syndrome (the "normal" grief experience, male/female grieving differences, emotional and behavioral changes associated with SIDS, etc.). It should be noted, however, that most of the support group meeting was spent discussing the stressful impact that Sudden Infant Death Syndrome had on the surviving parents and other family members. Additionally, many parents felt comfortable expressing their grief only with other parents who had a experienced a similar life crisis.

One mother recalls that she initially chose not to attend the meetings. However, after a few weeks she began to attend because she was experiencing difficulty understanding and coping with the changes which were occurring. She was unable to sleep, eat, or concentrate. She had not experienced these changes with any other death, and did not know how to deal with them. She thought the SIDS support group might help her not only understand what was happening, but to feel "normal" again.

Another mother stated that she could not discuss her emotions because she believed no one could understand what she was experiencing. The SIDS meetings helped her because she felt that she could express herself there, since these individuals shared similar experiences.

A mother who lost an infant to SIDS in the early 1970s, before counseling was available, recalls that she experienced difficulty coping with the

changes which followed for two reasons. First, she knew little about SIDS, and the information available at the time was sparse and difficult to obtain. Further, there were no support groups for SIDS parents in her town. As a result, she felt alone in her grief. She believes that the grief process might have been a less difficult experience had there been other SIDS parents with whom to discuss her sense of loss and grief.

Parents who participated in the SIDS support group were not only better able to cope with their own grief, but they were also better able to cope with the reactions of their spouses, other family members, and friends to the death of their infant. The information which they received in the support meetings helped parents not only understand their own grief, but also made them aware of different grief styles and reactions.

One woman stated that initially she was very angry with her husband. He was rarely willing to listen to her when she wished to discuss their child, and he always seemed to avoid the topic. She began to think that her husband was not grieving the death of their son. However, after attending SIDS meetings and talking to other women, she learned that many of their husbands had similar reactions to the deaths of their infants. Other men in the group informed her that simply because her husband was not openly expressing his grief did not mean was not grieving.

One man who participated in the meetings stated that he often became angry when relatives or friends made inconsiderate or tactless comments about the death of the infant. The support group helped him to realize these individuals were not deliberately rude or callous. Rather, it was their ignorance concerning SIDS which caused them to make these remarks. As a result, he learned how to respond to these comments.

These interviews illustrate that the SIDS support group is helpful to parents, since it assists both parents in understanding and coping with the adverse effects of stress associated with Sudden Infant Death Syndrome. While women are more likely to be participants in the SIDS support group, men who do participate also derive some benefit. Perhaps a modification of the structure of support groups would increase the benefits of the SID support group for men. Therefore, men would not only be more likely to join, but also to participate.

In conclusion, it is evident that the support received in these SIDS support group meetings helps parents to cope more effectively with their grief and the stress associated with a sudden death. It furnishes parents with the necessary SIDS information, which reduces the risk that ignorance regarding SIDS will result in pathological grief and adverse consequences. The support group helps parents feel less isolated in their grief and helps them cope with the stress which normally follows a death of this nature.

Additionally, the group may force parents to address issues which they may have avoided and which may have contributed to adverse behavioral changes or deterioration of certain relationships. In short, the emotional support available to SIDS parents who participate in the SIDS support group meetings decreases the amount of stress experienced after this type of sudden death, and therefore facilitates the SIDS grief process.

Social Support Systems and SIDS Support Group Participation

The majority of SIDS parents found initial participation in the SIDS support group beneficial because they acquired a better understanding of their own grief and bereavement process as well as the different grieving styles of men and women. However, the interviews revealed that only a minority of SIDS parents continued to attend the SIDS support group meetings on a regular basis.

The interviews revealed that those parents who did continue to attend the support group meetings did so because they had experienced a great deal of difficulty coping with the death and the adverse effects of Sudden Infant Death Syndrome stress. Their reactions to the death were also reportedly more intense. A mother who continues to attend the SIDS sessions responded that the SIDS death of her child was the most difficult experience with which she had ever dealt. The emotional and behavioral changes which followed the death were too intense for her to deal with alone. The continued support of others who had shared similar experiences was needed at this time in her life. Although the death has become less painful over the years, even today there are times when she feels the need to talk to someone. She is glad the SIDS organization is available to her.

In contrast, one father stated that he had attended only one or two meetings. Although he found the SIDS information helpful, he felt that in order to progress in his grief, he could not continue to dwell on the death. Continuously discussing the death of his child would not allow him such progress.

It is evident, then, that while the SIDS support group meetings were helpful to parents, the parents' sentiments or philosophy on how best to cope with death, bereavement, and grief determined whether or not they would continue to be regular participants in the support group meetings. Parents who did not feel the need for continued intervention attended only a few meetings. However, parents experiencing greater difficulty dealing with the death continued to attend the meetings and to benefit from them.

The interviews also revealed that parents who elected not to continue to attend the SIDS support group meetings often stopped because they had

other social support systems available to them. One mother stated that although she did find the group helpful, she preferred to turn to her church group for support. These were individuals who had helped her in the past and she felt comfortable with them. Another couple recalled that although they found it beneficial to listen to the experiences of other SIDS parents, their own families provided them with all of the emotional support they needed. One father also stated that while the group did help him understand some of the changes which were occurring, he felt comfortable expressing his emotions and fears only to his wife.

The interviews further revealed that SIDS parents who continued to attend meetings usually did so because they had no other support systems available, or because the support systems which were available to them prior to the death of their child were no longer accessible. One woman recalled that she tried to discuss her feelings with her husband and her mother. However, they did not want to listen. She began attending SIDS meetings and found that these people were not only willing to listen to her, but could also relate to her experience. One father recalled that he and his wife had recently separated, so he could not turn to her for support. His friends and family also were not very supportive of him during this difficult time. The support group meetings were the only place he felt he could express himself. Another women recalled the communication with her husband worsened after the death. She could not comfortably discuss the infant with him. Further, since she had never felt comfortable discussing anything with her family, she felt very alone.

An interesting anomaly emerged from the interviews. Some of the women stated that they attended only a few meetings, because their continued participation in the support group had created conflict in their marital relationships. One woman's experience reflected the experiences of many other women who expressed similar sentiments. This woman stated that while she felt the SIDS group had helped her a great deal, she stopped attending the meetings because she did not like attending by herself and her husband refused to attend. Further, when she did attend the meetings by herself, she always had the sense that her husband was angry. Consequently, she recalled that the first few months after the death of her infant were a difficult time in her marriage.

In conclusion, the results of this study indicate that parents who had access to emotional support groups usually did not feel the need to continue to attend the support group meetings. They felt most at ease expressing themselves with individuals with whom they were familiar. Parents who did not have a support group available to them (family, church, or otherwise) found continued participation in the meetings most beneficial.

The interviews provided support for the hypotheses put forth in this research study. The availability of social support systems was found to decrease the adverse effects of Sudden Infant Death Syndrome stress. Additionally, this study demonstrated that the SIDS support group helped to facilitate parents' grief process, particularly for those parents who had no other support system available.

Conclusions

This research study yielded support for the stress-buffer model of social support. The interviews revealed that the availability of social support systems is essential to the healthy resolution of SIDS parental grief. Those parents who have social support systems available to them experience fewer adverse effects of Sudden Infant Death Syndrome stress. Additionally, while parents who have support systems available to them are less likely to continue their participation in the SIDS support group, they nonetheless find this helpful in the initial stages of their grieving process.

The necessity of social support systems in coping with Sudden Infant Death Syndrome was particularly evident in the interviews with parents who lacked social support systems. These parents reported experiencing more adverse effects of Sudden Infant Death Syndrome stress, and most sought social support in coping with their loss and grief. Since the SIDS support group was available to them, many utilized its services. These parents reported that being able to share their experiences and listen to those of other SIDS parents was helpful in facilitating their own grief. Their ability to access a support group resulted in a decrease in the adverse effects of SIDS stress.

The significance of social support in coping with life event stressors is further evidenced by the fact that those parents who had other support systems available were more likely to continue to be active members of the SIDS support group than those who did have support systems available. This study, therefore, concludes that social support does act as a buffer against the adverse effects of life event stressors such as sudden death.

Implications

Since this study has demonstrated that the SIDS support group is helpful to parents in facilitating their grief, every attempt to make such support groups available and accessible to parents should be made. Special efforts should be made by the Sudden Infant Death Syndrome Agency to identify

parents who lack support group systems, since these are the parents to whom the agency could provide the greatest service. Further, since research has shown that men are less likely to participate in support groups, it is especially important for the SIDS Agency to engage in additional attempts to recruit men to participate in the support group. It is important for the SIDS support group to acknowledge that men are less comfortable expressing themselves in support groups, and to implement this knowledge into their efforts to make participation more desirable to men. If support groups are aware of these differences in grieving, they will be able to modify their support group structures and "counseling" techniques to meet the needs of both parents.

The ability of SIDS support groups to modify their structure to meet the needs of SIDS parents will certainly increase the groups' effectiveness. Although continued participation in the support group may not be necessary for all parents in resolution of their grief, its availability immediately after the death is important, since it provides parents with information concerning SIDS and the normal grieving process associated with this life crisis. If parents who are grieving feel the support group is responsive to their needs, they will be more likely to participate.

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Taking Back a Rich Tradition: A Sociological Approach to Workplace and Industrial Change in the Global Economy

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ABSTRACT

Sociology possesses a rich and deep tradition in the field of industry, work and organizations However, its past preeminence in the field lies encrusted under layers of research and practice done by those in other disciplines This is particularly disappointing with regard to the absence of sociologists' involvement in the momentous changes overtaking the industrial landscape—the move to more flexible and participatory workplace arrangements Part of the problem is the lack of a coherent theoretical framework to help locate a distinctively sociological approach and provide a clear clinical role for sociologists This article attempts to "take back" sociology's considerable heritage with regard to workplace and industrial change. It does so by locating sociology within the field and by focusing on the theoretical, methodological, and practice dimensions of three prominent practitioners The distinguishing features of the work of these practitioners are presented and the outlines of an expanded sociological approach and clinical role are proposed

The current transformation of industry and the workplace is without precedent, and it is irreversible. The scope and magnitude of the transformation may even surpass that of the Industrial Revolution. Profound changes in technology, the global economy, the workforce, national and international politics, market structures, and the organization of work and production have required a fundamental rethinking of the nature of industrial society. We are on the threshold of an entirely new era (Bluestone & Harrison, 1982; Finkelstein, Harrick & Sultan, 1991; Reich, 1983; Sable & Piore, 1984; Zuboff, 1988).

Although the enormity of industrial change appears indisputable, the work of American sociologists in this area, particularly with regard to applied research and practice, is clearly lacking. Sociologists, for the most part, have utterly failed to follow through on the promise of a rich and deep tradition. For example, in terms of theory, classical sociology's central preoccupation with industrialization, work, production, and organization, as well as contemporary sociology's emphasis on "post-industrial society" have become relatively marginal in the literature. Recent efforts have been made to resuscitate economic sociology in an attempt to "take back" what sociology has lost to economics (Block, 1990), or to integrate the two disciplines more effectively (Etzioni, 1988). Unfortunately, the losses and inadequacies are likely far too extensive for this.

Industrial sociology has probably been the greatesr victim. Most of us are familiar with the role of sociology in helping to found the field of Human Relations in industry in the 1930s and 1940s. As sociology's active involvement in industry began to evaporate in the post WWII period, the field became diffused and fragmented into areas such as complex organizations, work, professions, and occupations. In the meantime, other disciplines took the lead in industry. Today the bulk of research and activity in the area of workplace and industrial change is being done by others: industrial psychologists, management, labor, and industrial relations specialists, labor economists, communications and human resource professionals, and a host of others from a variety of applied fields. Indeed, Miller (1984) maintains that, "the best industrial sociology is now found in the business schools." A recent study of the 80 most important journals reporting on the behavioral and organizational aspects of management revealed that not one American Sociological Association journal is ranked in the top twenty-five (Extejt & Smith, 1990).

Closely related to the decline of industrial sociology is the disinterest and unwillingness of those in the discipline to engage in applied research. Clinical and applied sociology in general has certainly had its difficulties in garnering support for its activities in the past three or four decades, but

few applied areas have been quite as starved of sustenance as has this one. As a consequence, applied graduate and undergraduate sociology programs which focus on work, organizations and industry are virtually non-existent (Finkelstein, in press). In view of the current transformation of industrial societies and the unique traditions of sociology in this regard, it is vital that these trends in the discipline be reversed. In short, there is a need to develop a distinctively sociological approach; one which not only provides the benefits of a broad analysis of industrial change, but which also offers systematic methods and strategies to bring about change.

The purpose of this article is to help accomplish this task. How should we proceed, given the absence of a cohesive literature to examine, or applied academic programs to guide us? first, I review and contrast the characteristics of other perspectives in the field of industry and the workplace with those of sociology. Secondly, I draw from the work and careers of three prominent figures in the field and sketch out a portrait of a common orientation. The three figures are W. F. Whyte, whose career spans the entire period of industrial sociology, including the rise of Human Relations; Warren G. Bennis, whose eclectic perspective and clinical practice became widely recognized in the 1960s as helping to found the field of Organizational Development; and finally, R. M. Kanter, who, perhaps, has recently gained the most notoriety, and who is now editor of the Harvard Business Review. Brief portraits of their work are drawn and analyzed in terms of: 1) theoretical frameworks, 2) research and methodological strategies and 3) practice and policy implications. Finally, I conclude by suggesting a more significant role for sociology in addressing global trends and an expanded and more coherent approach for doing so.

Contrasting Perspectives: The Applied Behavioral Sciences

Few areas of study feature the kaleidoscope of perspectives which can be found in theories of changing work organizations and industry. Outside of sociology, these theories fall variously within such growing fields as organizational development, organizational behavior, management, personnel, industrial relations, or, more generally, they are regarded as rooted in the "applied behavioral sciences." All of these fields share several common characteristics.

First, they developed out of a critique of classical management principles which prescribed formal organization structures and mechanistic processes. They have a common origin in the works of Elton Mayo, Rothlisberger and Dickson, and Chester Barnard, who are often credited

with "discovering" the significance of informal, natural social systems, and who gave birth to human relations theory and practice. Secondly, these fields are concerned almost exclusively with social-psychological processes, such as employee motivation, satisfaction, superior-subordinate relationships, leadership, and other managerial-related topics. The third common characteristic underlines a more contemporary emphasis on organizations as open systems in which the nature of the "environment" (e.g., technology, economics, and social values) has a critical impact on organizational operations (Perrow, 1986).

In this regard, contingency theory has emerged as the most prevalent conceptualization of organization-environment relationships. Following the "organic," or "natural" model, organizations are seen as adapting to changes in the environment. The practical implication of this theory is the prescription that management find the right fit between the nature of the environment and internal organization structures and operations (Morgan, 1986). Here, the social-psychological dimension again remains central, as managers are charged with adapting the work force to meet the changing organizational needs. This has often meant developing managerial techniques in employee participation, team building, and group facilitation. This clear connection to application and practice is the final characteristic common to these fields. That is, specific skills in these areas are lacking across the American industrial landscape, and there is a boom in the popular business literature and in consulting firms which foster their development (Tjosvold, 1986).

Despite past concerns that research conform to formal notions of scientific inquiry (e.g., research must be disinterested, uninvolved, value free, and predictive), these fields have become increasingly applied. This does not mean that they have resolved the basic research issues. It merely suggests that there is a general recognition of the inescapable normative implications rooted in research efforts in these fields, and that the strong demand for research to afford practical applications has led to a greater acceptance of applied work (Lorsch, 1979).

Significantly, most of the applied perspectives considered thus far understand change within a fairly narrow set of parameters, since the primary unit of analysis remains the individual. Moreover, as Burrell and Morgan (1979) point out, much of social science, and especially industrial sociology and psychology, organization theory, and industrial relations, has been dominated by a paradigm that has been confining in its orientation toward change and the methods used to investigate human activity in general. As we shall see, these limitations help identify the contributions sociology has

made in the past, but more importantly, encouraged sociologists to pursue the greatly expanded approach taken by leading practitioners.

Why a Sociological Approach? Sociological Theories of the Workplace

Industrial and organizational sociology claim a similar theoretical heritage to the variants of applied behavioral science, but assert a longstanding tradition of concern with society-organization interrelationships. Moreover, sociological practice in this field has historically been concerned with broad based change efforts (Fritz & Clark, 1989). Intervention in social activity has been understood by industrial sociologists in terms of "quantum" levels of interest: personal, group, organizational, and social world (Straus, 1984).

Additionally, the sociological perspective has emphasized organizational and structural processes over narrowly conceived social-psychological ones. For example, although criticized for its apparent restricted and closed model of organization, Max Weber's classic work on bureaucracy was, of course, part of his overall macro-historical account of the rise of modern industrial society. Non-sociologists, in particular, often sketch out the bureaucratic characteristics which were presented in Weber's ideal type, while simultaneously losing sight of his most important observations—that modern organizations were increasingly becoming societal instruments of domination (Fischer & Sirianni, 1984).

The Human Relations School, itself, may be traced back to Durkheimian sociology and the rise of structural functionalist theory. This theoretical tradition firmly grounded the study of organizations in an institutional context and in the larger social system. Nevertheless, studies in human relations have been criticized for narrowly focusing on the attitudes, beliefs, and subjective states of individuals in order to predict behavior. Perrow (1986), for example, argues that, "One cannot explain organizations by explaining the attitudes and behavior of individuals or even small groups within them. We learn a great deal about psychology and social psychology, but little about organizations per se in this fashion. In fact, what we are learning about psychology and social psychology from these studies may be an outmoded psychology and social psychology."

Symbolic interactionists have, of course, long recognized the error in thinking that we might somehow measure the objective features of manager-employee-group relations based on presumed social psychological predispositions, and then suggest causal relationships among these features as discrete variables for the purpose of prediction (Denzin, 1983). Such a view

often fails to recognize employees as active agents and creators of workplace realities as opposed to passive recipients or carriers of attitudes.

More recently, the population-ecology model, or natural selection perspective, and the resource-dependency model have stressed the fundamental importance of interorganizational relationships in a highly competitive environment. According to these models, those organizations which collaborate and negotiate with other organizational entities will be in a better position to adapt and attain the scarce resources necessary for their survival (Hall, 1991).

Moreover, these theoretical models share common concerns with the political-economical approach to industry. Those advancing this perspective in sociology have long attempted to root organizational processes in the larger social context of the conflict over resources and the control of the production process. They have asserted a management bias in more conventional analyses because of the assumptions they have made regarding the class structure of organizations and because of their disregard for the divergent goals and interests of the participants. For example, the critique of modern management methods as a strategy of "deskilling" has stimulated a reexamination of managerial practices and a movement toward more participatory forms of production and organization (Derber & Schwartz, 1983).

The applied behavioral sciences have drawn and benefitted from the sociological tradition, yet virtually all of these fields have grown and advanced while sociology has declined. Why so? Two interconnected explanations come to mind. First, a sociological perspective was likely to be more critical of work and industry arrangements because it broadened the investigation and highlighted power relationships. This had already become evident in such studies as the *Man On The Assembly Line* (Walker & Guest, 1952) and *Automobile Workers and the American Dream* (Chinoy, 1955), which exposed the oppressive nature of the factory, even though they saw little possibility for an alternative set of arrangements; and the work of Robert Blauner (1964), whose groundbreaking research offered a view toward skilled and autonomous industrial work, while examining the alienating characteristics of modern industrial production.

Secondly, sociology's broadness and potentially critical orientation made it less desirable and applicable, compared to the emerging behavioral sciences, which promised a more practical approach to solving managerial problems and to dealing with individuals, rather then dealing with the wider structural or institutional processes. Meanwhile, sociology began to emphasize basic research, and distanced itself from clinical settings. The dominance of formalistic protocol in scientific research discouraged practical

applications. The rise of conflict perspectives in the 1960s and 1970s made involvement anathema for many interested in the field. Thus, sociology, though obviously endowed with the capacity to become a powerful force in this arena, abandoned opportunities to fulfill its potential.

The premise here, however, is that times and conditions have changed dramatically. The onset of global, industrial, and workplace change have made institutional, societal, and international relationships a dominant factor in workplace and organizational dynamics. Continuous and reciprocal interrelationships among organizations, both private and public, are a key feature of this change. The current myriad of socio-economic problems in the U.S., including trade and budget deficits, plant closings and unemployment, skills shortages and educational inadequacy, work and family demands, and racial and gender discrimination, are traceable to national inattention to the scope and implications of such global changes. Restrictive individual and social-psychological based analyses are insufficient to the task of understanding modern industrial change.

The splintering of global markets and the need for flexibility in production to deal with a multiplicity of demands, means that employers must place far greater emphasis on developing the skills, knowledge, participation, and commitment of a culturally and racially diverse work force. To support this enhanced and increasingly diverse workforce will require unprecedented partnerships among major institutions: industry, government, education, and labor. Thus, to some extent, the traditionally opposing interests of employer and employee may be recast in a context of the need for mutual obligations, employee rights, information sharing, participation in decision making, opportunities for employee ownership, and the like. A greater emphasis on more democratic industrial and workplace relationships has become clearly visible.

This means that not only has a sociological approach become an indispensible aspect of research and practice, but that moral and ethical problems concerning such activities are less sharply drawn and may be more readily resolvable. Indeed, those who regard social and organizational change as an important goal should find this area of inquiry particularly attractive. Nevertheless, most sociologists have continued to avoid involvement in this wide-ranging field and have largely failed to realize the inherent strengths and benefits of their own approach (Finkelstein, 1990).

Our next task is to provide examples of exceptions to this claim by overviewing theoretical, methodological, and practice dimensions of three prominent individuals. In each of these dimensions, summary statements will be presented as a way of helping to formulate a distinctively sociological approach. It should become apparent that such an approach is an

attempt to substantially broaden the paradigm for activity in this field. The overall framework presented is as much a challenge to sociologists to join in this effort as it is a statement of sociological practice.

Portraits of the Sociological Perspective

The Theoretical Dimension

William Foote Whyte was one of the pioneers of the Human Relations movement. In a recent self-reflective critique, Whyte argued that not enough attention was paid in Human Relations to forces external to the interpersonal relations among managers and employees (1987). Nevertheless, in his groundbreaking research of the restaurant industry (1948), Whyte not only contended that the structure of social relationships highly influenced employee motivation and productivity, he offered particular solutions to solve problems of inefficiency, low morale, and high turnover. Whyte's classic solution of the "spindle" to the problems of status inconsistency in a restaurant has often been used to illustrate the importance of the workplace as a social system rather than as merely a set of assorted component parts (Porter, 1987).

Over the years, Whyte's perspective has widened to provide theoretical insights into the issues of worker ownership and control (Whyte & Blasi, 1982). The culmination of these efforts is illustrated in his recent analysis of Mondragon, the worker cooperative complex in the Basque region of Spain (1988). For Whyte, the worker cooperative represents an important alternative, and a social experiment in developing new forms of industrial organization. In his analysis, he introduces us to the importance of relationships between organizational, political, and economic processes. Whyte has recently mounted a penetrating critique of sociology in the university (Whyte, 1991). He calls for greater efforts to connect research and practice and urges interdiciplinary approaches which vigorously integrate social science with the technical aspects of work and industry.

This broadening and deepening of the field has also been a distinguishing trademark of Warren G. Bennis, longtime advocate of applying knowledge to create change (Bennis, et al., 1984). More specifically, Bennis' career exhibits an unrelenting effort to critique and transform business management and education by drawing on the behavioral sciences and arguing for organizational development and social change (1966). His academic training at MIT was broad and interdisciplinary. He was one of the first to enlarge the boundaries of social psychology, as an organizational

clinician. Indeed, a closer reading of his work demonstrates that he has especially relied on sociology to draw vital connections between the need for micro and macro changes.

For example, he and sociologist Philip Slater wrote a series of farsighted essays in the 1960s, in which they overviewed the constraints inhibiting American institutions and proposed new ways of thinking about overcoming the constraints (1968). In fact, one of these essays, originally published in 1964 and entitled, "The Inevitability of Democracy," has recently been reprinted in the *Harvard Business Review* to mark its profound and continued relevance in the contemporary scene (1990). In this article, they argued that democratic forms of organization would be necessary, if not inevitable, in order for entire social systems to be able to successfully solve complex problems and survive in a changing world. This approach was reflected in Bennis' focus on bureaucracy and the need for organizational change. He was a founder of the organizational development movement and he has had a determining influence on the shape of movement (1969). All of his work has been directed toward bridging the gap between theory and practice for the purpose of making changes that are deliberate and collaborative.

Rosabeth Moss Kanter followed a similar path to her predecessors, but has sought to break new ground and enlarge the terrain of change by emphasizing a structural analysis. This was evident in her first major work, in which she studied the relationship between individual commitment and the community (1972). Rather than view commitment as primarily a social psychological or attitudinal phenomena, she focused on the structural mechanisms which fostered and sustained high levels of commitment. Her now classic study, *Men and Women of the Corporation*, applied this thesis to the realm of large scale bureaucratic organizations. She found that the structure of corporate bureaucracies limited opportunities for individual growth, created powerless positions which stifled innovation and creativity, and demotivated organizational members, not only women and minorities, who were the most vulnerable, but anyone who was not on the "fast track." Her calls for "flattening out the hierarchy" and fostering "empowerment" have now become standard concepts in the organizational change literature. Her more recent research is rooted in a social structural approach to organizational change which highlights the interconnections between changing demographics, new technology, and the globalization of the economy (1983).

In summary, there are theoretical elements common to the portraits presented thus far, which may help us formulate an expansive sociological approach:

— a macro-historical and structural perspective
— attention to multi-level analysis, especially micro-macro connections
— a critique of psychological reductionism
— an emphasis on institutional and political-economic processes
— an emphasis on a close relationship between theory and practice for the purpose of social change.

The Methodological Dimension

It should not be surprising that this theoretical orientation calls for methodologies that are action-based. Data are collected and analyzed in the process of a close interactive relationship between the researcher and those in the research setting. Traditional rules of scientific conduct stressing disinterest, distance, and objectivity are mediated by a concern for solving problems and producing changes. There is an effort to coordinate the involvement of workplace members in the research as a part of the change process.

For example, W. F. Whyte was one of the first social scientists to develop field methods that could be directly applied to the workplace. He was one of the pioneers of participant observation and qualitatively based research, which became well known in his classic work, *Street Corner Society* (1943). His classic account of the restaurant industry utilized such procedures and was instrumental in making changes in the organization of restaurant work (1948).

Over the years, Whyte has consistently argued that the methods of the natural sciences may be less appropriate, particularly in applied settings, where the solutions to problems may call for "social inventions" (Whyte, 1982). According to Whyte, these social inventions come from within the organization or community itself and come out of a research process in which the researchers are immersed in the activities of the participants.

Whyte's methodological innovations have recently been formulated in a more systematic approach directly related to workplace change, which he calls "participatory action research," or PAR (1989). A central element of PAR is that practitioners (managers, employees, stewards, owners) in the research setting participate in the research process. Whyte argues that such collaboration will help to integrate knowledge and methods in a way that will advance scientific research while solving practical workplace problems. He demonstrates that research can be engaging and client-centered.

Warren Bennis has long advocated such clinical procedures in his work in organizational development. His whole idea of planned change which emerged in the 1960s dealt with generating knowledge out of a mutual col-

laboration with the client organization; a mutual determination of research goals; client-practitioner involvement at each stage of the research process; continuous clarification of goals and information gathering; and reciprocal feedback, learning, and assessment as an ongoing part of organizational operations (1969). These elements are considered essential for providing information that is both accurate and practical. Bennis was one of the leaders in the development of sensitivity training, or lab training, for practitioners, in which "T-groups" became a way for social scientists to more effectively facilitate and consult with managers and corporate executives in information sharing and problem solving efforts (1966). Since then, these kinds of techniques have blossomed into an array of small group activities that bring together employees from all levels and locations of the organization.

As a way of accomplishing many of the goals associated with an action-research approach, Rosabeth Moss Kanter has become a master of the art of case study analysis. Her research is characterized by the simultaneous use of several methodologies—survey questionnaires, interviews, content analysis, field observation—all in an effort to avoid what she calls taking "snap shots" and to instead create "movies" that tell the story of organizational change while simultaneously facilitating those changes (1983). Such an approach presents a picture that is rich with description and shared meanings of organizational realities as they unfold. In this sense, Kanter is an organizational historian with an eye toward the future. Data is oriented toward documenting and creating change. She is keenly aware of her role as a "change master," who must always present research findings in such a way that they will permit the client organization and the participants to move on to the next stage. Kanter's approach is characterized by an understanding of how the research process itself may affect those in the research setting.

Thus, the characteristics of research methods likely to inform a more penetrating sociological approach to industrial and workplace change:

— are participatory action oriented
— are interactive and collaborative
— link theory and method
— use multiple and diverse data gathering techniques
— are directed toward solving problems and making changes.

The Practice and Policy Dimension

All of these applied sociologists are experienced consultants to industry, but the scope of their efforts goes far beyond the traditional role of the

industrial consultant, which has most often been confined to fee for service activities offered to individual firms. These practitioners are architects of broadly conceived change strategies which involve individuals, groups, organizations, communities, and societies worldwide. Sociological practice has been redefined by them as global practice.

Warren Bennis was a pioneer of laboratory training techniques, such as T-groups, survey feedback, and organizational assessment. These techniques were designed to encourage organizational members to become more sensitive to each other's needs, to learn to be mutually supportive and cooperative, and to orient their knowledge toward action-based solutions. All of this Bennis continues to refine today as part of the organizational development strategy. He was one of those who coined the term "change agent" in the 1960s, but he has since advocated that OD efforts be aimed at broader labor-management problems, the problems associated with plant closings, and at multinational corporate restructuring. Bennis has argued that more and more organizational decisions are public decisions, with a multiplicity of constituencies and stakeholders. "No longer can the management of external relations be left exclusively to the public affairs department. Top leadership and OD practitioners must be involved directly. In short, the political role of organizations must be reconceived." (1987, p.43)

Rosabeth Moss Kanter is among those in the field calling for fundamental organizational and structural change strategies such as employee participation, project teams, Quality of Worklife, and labor management cooperation. In addition, she has advocated equal opportunity employment and affirmative action as a means to counteract the problems of tokenism in predominantly white and male organizations. These practice strategies constitute an approach oriented toward changing the structure of opportunities for people of all levels of the organization, and especially those traditionally excluded, to get involved in higher level problem solving and decision making.

In the *Change Masters*, she identifies "power tools"—information, resources, and support necessary to empower organization members, provide them with greater input, and spur innovation and creativity. In her most recent book, she provides a practical analysis of the ways organization members can work together and with other organizations by pooling resources and forming partnerships and alliances (1989). Moreover, she summarizes ten national policy recommendations and the kinds of strategies which she advocated as a major adviser to the 1990 Dukakis campaign:

> a human resource development tax credit; industry-level training partnerships; accelerated technology and language education; union-management partnerships to plan workplace changes; incentives for profit sharing and performance bonuses; stronger safety nets for displaced employees; daycare; flex-year opportunities; flexible use of severance and unemployment benefits; and portable pensions. (1989, p.366)

Finally, W. F. Whyte has developed and directed Cornell University's Programs for Employment and Workplace Systems, where research and practice in developing employee-owned and -run organizations is carried out. In the 1980s, these efforts spawned several projects in which the PAR (participatory action research) approach was specifically utilized. For example, Whyte's program became involved with Xerox Corporation and the Amalgamated Clothing and Textile Workers Union (ACTWU) on a joint project designed to address the declining market share and competitive position of the company. A major result was the "cost study team"—which Whyte has termed a "social invention" because it emerged out of the PAR process. Not only did labor and management find ways to jointly cut costs and save jobs, the project led to important research findings on the relationship between employee participation and productivity (1989).

Another project in which the Cornell program implemented the PAR approach was the FAGOR group of cooperatives in Mondragon, the oldest and largest cooperative complex in Spain. The PAR process in this case investigated cultural processes that encouraged or inhibited participation in decision making. Researchers found that studying the causes of apathetic attitudes was less helpful than discovering the formal and informal structures which might be reorganized to foster greater cooperative relationships. One of the outcomes of this project is that PAR is becoming incorporated into the FAGOR personnel program (1989).

In his book, *The Making of Mondragon*, Whyte gives much importance to the role of applied sociology in the historical development of the American industrial cooperative. In fulfilling such a role, he has provided assistance in the writing of national legislation designed to foster worker cooperatives and has worked with the Employee Stock Ownership Association and the National Center for Employee Ownership. In addition, Whyte has advocated that state universities develop assistance capabilities to aid community efforts on the model of an Agricultural Extension Service. Applied and clinical sociology might then be integrated into the technical assistance and resource programs, such as engineering or accounting, and

consultation could be provided for those interested in cooperative industrial relations and planned change (Whyte & Boynton, 1984).

In sum, these practitioners see themselves as:

— change agents and change masters
— clinicians of change, human resource and organizational development practitioners
— policy advisors and consultants
— developers and providers of educational, training, research and consulting programs and services.

Conclusion

Sociology has an important role to play in the current transformation sweeping the global economy and the workplace. Macro structural change of unprecedented proportions requires a broad multi-level theoretical perspective, and a variety of closely connected methodologies, techniques, applications, and clinical procedures capable of addressing global problems and trends. Other applied disciplines have flourished in this field, yet they often remain limited to narrowly conceived social-psychological accounts and an overly restrictive conceptual paradigm. The strength of sociology is rooted in its broad applicability.

We see these strengths in the approaches of practitioners such as Kanter, Bennis, and Whyte. Taken together, these practitioners advance a greatly expanded paradigm for sociological activity in this field. Their theoretical perspectives stress inextricable connections among theory, method, and practice, and between micro- and macro-processes. Their perspectives reflect innovations in applied research and clinical practice. These innovations encompass the global transformation of work; fundamental structural and organizational change; cooperative ownership and decision making; work/family and race/gender relations; and greater participatory and democratic arrangements. They argue that theory building is a transformative process and will progress insofar as it is based on action research and is derived out of an effort to change existing social contexts. They are actively engaged in developing programs and services which foster social change.

Sociology's rich tradition in industry and the workplace is surpassed only by its future promise. Much needs to be done in order to ensure that this promise is fulfilled.

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Advancing Toledo's Neighborhood Movement through Participatory Action Research: Integrating Activist and Academic Approaches

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ABSTRACT

This paper first develops the methodology of participatory action research as a research process originating from community-defined needs, involving community members in conducting the research, and leading to community-based action Within this research model, we discuss the difficulty of integrating the roles of activist and researcher Secondly, the paper describes the outcomes of the coordinated efforts of an activist academic and a professional community organizer who have engaged in a series of research projects to increase the organizational effectiveness and urban redevelopment capacity of community-based development organizations in Toledo, Ohio. Thirdly, the paper evaluates our project, discussing how we addressed the problem of integrating activist and researcher roles

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Introduction

Community-based development organizations, or CBDOs, are the new hope for successful urban development. Efforts to conduct urban redevelopment through centralized government and corporate controlled planning processes have often not met the needs of citizens, and have even been met by citizen resistance (Henig, 1982; Worthy, 1976). The community-based organizations which emerged in the 1970s in an attempt to halt projects, from high-rise construction in Minneapolis (Stoecker, 1988) to highway expansion in Toledo (Melvin, 1986), have given rise to proactive community-based development organizations in the 1980s. The proactive CBDOs are often as successful in creating development as the reactive organizations were in preventing it (Giloth & Mier, 1989). The Federally-established National Commission on Neighborhoods (1979) concluded that authority could be better exercised, programs could be better administered, and public funds could be better spent at the neighborhood level. Ten years later the national non-profit Center for Community Change (1988) provided examples of multiple cases where CBDOs were viable alternatives to centralized urban redevelopment planning. Finally, the 1990 National Affordable Housing Act endorsed CBDOs and set aside funds for CBDO projects (Center for Community Change, 1991).

Yet, these organizations do not always succeed. Many fail even to organize effectively, and many who do organize end up accomplishing very little. The burdens borne by CBDOs are tremendous—they must act as realtors, bankers, developers, and politicians all rolled into one as they attempt to refurbish their community housing and reinvigorate their local economies. The work they do is highly technical, filled with political and financial trap doors, and is extraordinarily expensive. Thus, CBDO members require access to highly specialized skills and to funding in order to purchase those skills.

When one CBDO fails to meet its goals, the tragedy is manageable, as other organizations often rise to take up the slack. When an entire city lacks effective CBDOs, however, the tragedy multiplies.

Can academic researchers play a direct role in improving the chances of success for CBDOs? If so, what is the role of the researcher in community-based development organization, and what is the relationship between the academic and the activist? This paper describes the outcomes of the coordinated efforts of an activist academic and a professional community organizer who have engaged in a "participatory action research" project to increase the organizational effectiveness and urban redevelopment capacity of community-based development organizations in Toledo, Ohio.

Participatory Action Research

The concept of participatory action research is drawn from the fields of community psychology and community development. Community development specialists have continued to refine what they have variously referred to as "community research" (Kelly, 1979; Kelly, Muñoz, & Snowden, 1979), "community-based research" (Snowden, Muñoz, & Kelly, 1979), "social action research" (Voth, 1979), and, most recently, "action research" (Lorion, Hightower, Work & Shockley, 1987: Truman, et al., 1985). Brown and Tandon (1983) distinguish the differing traditions of "action research" and "participatory research", and argue that participatory research provides community members with more control over the research process and emphasizes structural change, as opposed to the individualistic approach of action research. The variant of "action research" used by community development activists is much closer to Brown and Tandon's "participatory research." In the latest attempt to bring the field into focus, Whyte (1991) has adopted the term "participatory action research" and applied it generally to projects which fall along the entire continuum from action research to participatory research. Thus, because we emphasized community control of the research process, even though structural transformation is a far-off goal, we will refer to our process as "participatory action research."

Voth (1979, p. 72) has developed the most complete definition of this research process using the term "action research:"

> Action research is research used as a tool or technique, an integral part of the community or organization in all aspects of the research process, and has as its objectives the acquisition of valid information, action, and the enhancement of the problem solving capabilities of the community or organization.

Voth (1979, p. 73) goes on to emphasize that this research process "almost always involves a commitment to problem solving and decision making *with* people instead of for them" [emphasis in original]. The ultimate goal of participatory action research is "helping community people to become subjects instead of objects, acting on their community situation instead of simply reacting" (Voth, 1979, p. 75).

There are three basic components to participatory action research. First, community-defined needs must generate the research design—not capitalist needs, not government needs, not the researcher's needs, but needs as defined by the community (Snowden, Muñoz & Kelly, 1979; Voth, 1979). Sometimes this is accomplished through surveys of the community (Goudy

& Tait, 1979; Truman, et al., 1985), and sometimes through community meetings (Jason, et al., 1988; Meeks, 1989). The researcher's role may often be to help community members to define their needs, and to balance the researcher's resources with the needs of the community.

The second basic component of participatory action research is that community members must be involved in carrying out the research itself by helping to design the research questions (Truman, et al., 1985), and by becoming involved in data-gathering (Goudy & Tait, 1979). "Basic sociology" researchers working in Marxist and feminist traditions have, in fact, been at the forefront of this "collaborative" research practice. Lather (1986) reviews examples of "research as praxis," showing how various researchers have involved the "subjects" of the research in the research process itself, both to check accuracy and to elicit further information. Luxton (1980) solicited help from the women of Flin Flon in designing her interview procedures in that community. Willis (1977), in his work in a British working class community, went back to community members themselves to review and comment on their work. This served both to elicit further information and to provide confirmation of the researcher's work.

This research collaboration is often taken one step further by community activists to include an additional level of "action"— community participation through political action with information as the goal. Barry Greever (n.d.) refers to this as "making the information the issue." He argues that oppressed people gain ownership of information by demanding it, and gain strength vis-a-vis their opposition by forcing power holders to give out information that is detrimental to their continuing abuse of power.

The third basic component of participatory action research is that the community must become involved in actually using the research results. In Sac City, Iowa, community leaders used a survey of residents in 27 rural towns to educate residents about their collective perceptions and to organize them to plan action programs and establish action priorities (Goudy & Tait, 1979). In Lansing, Michigan, the initial results of the action research were distributed and discussed at a neighborhood meeting. The reactions to that research resulted in a longer draft of the results, and led to plans for a neighborhood watch program, an expansion of the food co-op, the development of a health clinic, and other services and future research plans (Truman, et al., 1985).

One issue that has not been clearly addressed by those writing in the broad area of participatory action research is how the roles of the researcher, who takes responsibility for carrying out the research, and the activist or organizer, who takes responsibility for community control of the research process and its action outcomes, relate to or clash with one

another. Should the researcher, as an expert, ever advocate a position, or do they serve as only a technician? Should the researcher and activist roles ever be combined?

There are two main problems facing the participatory action researcher in the community which seem to point to the importance of the organizer role. First, community members must be convinced that it is in their best interest to give this researcher their time, to answer what may appear to be a lot of stupid or irrelevant questions, and to trust that the answers will be used wisely. Participatory action researchers widely agree that one of the initial problems facing the researcher is overcoming community members' distrust of outsider experts (Jason, et al., 1983; Kelly, 1979; Kelly, Muñoz & Snowden, 1979). To the extent that the researcher develops a solid knowledge of the political and social dynamics of the community (Kelly, 1979; Kelly, Muñoz & Snowden, 1979), is sponsored by recognized legitimate community leadership, creates a community-based research program guided by the community, and conducts the research with the participation of recognized leaders, however, he or she will be able to overcome some of this distrust. The organizer can sponsor the researcher into the community in a way the researcher might not be able to accomplish on his own.

A second major problem concerns the role of the researcher in the decision-making process surrounding the research. The researcher may be called upon to engage the community in the research, interpret research results, and evaluate various action options in light of the research findings (Jason, et al., 1988). Favero (1937) classifies community decision making into three different styles, based on the role which the community development specialist plays in the decision-making process. "Informed decisions" may be made through any of a number of processes, but the specialist provides only knowledge and does not make any recommendations or advocate any positions. When the specialist organizes a democratic decision making process but does not advocate any position in that process, "democratic decisions" occur. "Just decisions" occur when the specialist advocates a particular position. Favero recognizes that it's almost impossible for the specialist not to advocate any position, but argues that the specialist should work toward democratic decisions rather than taking a conscious advocacy role. For the participatory action researcher, the more involved the researcher in interpreting the research and directing the decision making, the greater the danger that they may advocate a particular interpretation of the research results and ultimately subvert participation. An organizer, however, can help build strong local leadership and develop a process which maintains the researcher's voice while also balancing it with the community voice.

What follows is a description of how an academic researcher and a community organizer joined forces in a participatory action research project. We will follow this description with a discussion of the strengths and weaknesses of the project, giving special attention to the advantages and disadvantages of separating the roles of activist and researcher.

Participatory Action Research for Toledo CBDOs

Toledo, Ohio, has poorly weathered the economic decline of the late 1970s and 1980s, and the Reagan restructuring. Much of the basic industry on which Toledo depended has left or is in the process of leaving. As a consequence, poverty is widespread, as are the problems which go hand in hand with poverty—abandoned and deteriorating housing, vandalism, crime, empty commercial storefronts, an absence of dignified and well-paying employment, and a lack of response by city government to the needs of low income neighborhoods.

In the absence of official recognition of community problems at either the local or the national level, CBDOs have sprung up across the city. Eleven have formed since the beginning of the Reagan administration. Sometimes this has involved the revival of an inactive organization, and sometimes it has involved the establishment of a brand new organization. Much of this CBDO activity has been haphazard, with little coalition or umbrella group planning.

In 1987, the University of Toledo Urban Affairs Center hired a half-time community organizer. Dave Beckwith was a long-time Toledo community organizer who was also working with the Washington D.C.-based Center for Community Change. In 1988 the Sociology, Anthropology, and Social Work department at the University of Toledo and the Urban Affairs Center jointly hired Randy Stoecker to work half-time in each unit. Randy had just finished a Ph.D. At the University of Minnesota, and had written a thesis on an activist neighborhood in Minneapolis which had successfully enacted a community-controlled urban renewal plan. Dave and Randy both came to the Urban Affairs Center, then, with a commitment to community-based urban revival.

The Initial Research

One of Dave's first acts at the Urban Affairs Center was to collect recommendations from Toledo CBDOs for needed research projects. The list which was generated included about twelve items ranging from an envi-

ronmental survey to a survey of daycare needs, and included a recommendation to conduct a needs assessment of Toledo CBDOs. Partly because of the match with Randy's skills, the CBDO needs assessment became the first community-based research project to be conducted as part of the new Urban Affairs Center program.

There were four strategic advantages to selecting a systematic review of Toledo neighborhood groups as a priority project. First, it would provide a 'bridge' between the Urban Affairs Center and these groups in a way that touched every group. This is similar to the weekly newspaper that lists the cub scout awards and the PTA attendance roster—people identify with a product that mentions their group. Secondly, the review would serve as the first step in bringing order and purpose into the disorganized world of Toledo community-based development and advocacy organizations. Thirdly, such a study could begin to focus public attention on the role that community groups already played in Toledo, building political power behind the effort to enhance this role. Finally, the study would quantify the unmet funding needs of Toledo's community-based development groups, a necessary first step in developing a strategy to meet these needs.

The participatory action research model guided the project. Randy drafted a preliminary interview guide and sent it to five central members of the Toledo CBDO movement who had been identified by Dave, and revised the draft based on their recommendations. Twenty-two community-based development groups (the complete population) in Toledo were identified through the recommendations of these central CBDO activists, and invited to participate.

The smallest had no operating budget and no staff; the largest had a $237,000 operating budget and three staff. We sent letters to either the board chairs or the executive directors of each of the CBDOs inviting them to a meeting to discuss the study. Those who attended the meeting then had the opportunity to comment on the interview guide. Those who did not attend were mailed a copy of the interview guide and were asked to comment on it. Randy collected all comments and rewrote the interview guide one last time.

Members of twenty of the twenty-two CBDOs were initially surveyed, and most were then followed up with a phone interview to better determine training needs and inter-organizational links. All research was completed between November, 1988 and February, 1989. A two page summary of the interview responses for each CBDO was prepared and mailed to the original contact to check for omissions and errors. A preliminary draft of the research results was then circulated to representatives of all CBDOs for

their comments, and a final draft was completed based on the corrections provided by CBDO members.

The findings of this research project were distressing. First, there was a terrible shortage of funding. The CBDOs identified $2,153,100 as the total core budget support which was needed—more than double their total actual funding level. The sources of funds available for core budget funding were extremely limited and there were fears among neighborhood groups that both city and private sources were drying up. There was also resentment between groups that CBDO funds were not distributed fairly, though the research showed that city funds to CBDOs generally corresponded to the level of need as measured by boarded-up housing and poverty rates.

Secondly, the geographic areas served by CBDOs often overlapped, usually without the knowledge of members of either organization, and there was very little inter-organizational coordination. Finally, many of the organizations barely existed. They had offices but no signs, only occasional newsletters, few or no staff, intermittent phone service, and generally lacked the skills to accomplish significant redevelopment or even to influence the course of redevelopment in their neighborhoods.

The Research Conference and the Working Group on Neighborhoods

In order to accomplish the study's goals, Dave proposed that the results should be presented at a spring conference. One objective of the conference would be to mobilize city officials, foundation representatives, and CBDO members to restructure and reinvigorate community-based development in Toledo. The key to accomplishing this was to structure the conference around the question "What are WE going to do about this problem that WE have?" to emphasize that foundations, the city, and CBDOs each had a role to play. Dave organized meetings with the editor of the only newspaper in Toledo, with our U.S. Congresswoman, and with the Toledo city council in order to "buy in" various interest groups in a non-threatening way.

Randy's participatory research practice helped to mobilize CBDO members. Each time we sent out drafts of the research results for CBDO members to critique we revealed more of the conference plans, to attempt to build interest and stress the conference's importance.

The conference, in June of 1989, was attended by government officials ranging from U.S. Congresswoman Kaptur to city housing officials (though the conservative mayor and most council members were absent), by a number of foundation officials, and by representatives from nearly all of the CBDOs. We began the conference with food, followed by short speeches,

a brief discussion of the research results (by this time most participants had read or been told the results two or three times), and then a brief question-answer session. The second part of the conference was organized to develop strategies to meet the challenges posed by the research results. We sent the CBDOs to one room and the government officials and funders to another, and asked each to develop a list of demands—what they wanted from the other group—and a list of what they would provide in return. A member of each group was recruited by Dave and Randy to facilitate their group, after consultation with CBDO members and city leaders, to ensure that potential facilitators were seen as being above hidden agendas or favoritism.

When we brought the two groups together at the end of the conference, there was amazing agreement. The CBDOs wanted long-term, stable, increased funding for operating expenses, in contrast to the short-term, unpredictable, low funding focused on project support which was currently available. In return, the CBDOs were willing to increase their skill levels, and were willing to create and submit to accountability mechanisms to prevent money from being wasted. The government-foundations group recognized the need to provide a different quality of financial support than was presently available, and the foundations, in particular, agreed to develop funding plans to provide for longer term, more predictable, and higher funding levels for operating expenses. In turn, they demanded that measures be developed to ensure that the money they were providing was actually having an impact.

With the great deal of energy generated by the level of agreement from the two groups, a core group of eight members (four from each group), along with Dave and Randy, agreed to meet to develop a plan to address the funding, interorganizational coordination, and development issues. With this core group eventually expanded to twelve to better represent the diversity of Toledo neighborhoods, the "Working Group on Neighborhoods" (WGN, pronounced "we gone") was formed from the original conference participants. The core group was responsible for scheduling meetings and agendas, and the members of this group eventually became the chairs of the four WGN subcommittees. One subcommittee was formed to develop an extensive training model for CBDO members, another was formed to develop and distribute a resource guide to all sources of technical assistance available to Toledo CBDOs. The third subcommittee was formed to organize and plan a study of the funding patterns and decision-making processes of all of the major Toledo foundations. The fourth subcommittee was formed to look at how CBDOs were funded in other cities and to eventually develop a plan for Toledo.

By the spring of 1990, all of the subcommittees had accomplished their tasks. The technical assistance subgroup, with funding and staff assistance from the city of Toledo, created, duplicated, and distributed a guide to technical resources for Toledo CBDOs. The funding model subgroup, led by the director of the Toledo Local Initiatives Support Corporation (LISC) and a neighborhood activist, created a plan to distribute funds to Toledo CBDOs in such a way as to maximize fairness and CBDO accountability.

Another neighborhood staffer, heading up the training subgroup, got a basic training program up and running in early 1990. Randy, co-chair of the funders study subgroup, began a new research project designed to increase understanding of Toledo-based philanthropic foundations and to increase foundation officials' understanding of CBDOs.

The last project, the foundation study, proved to be the most difficult. The goal of the study was first to understand the distribution of philanthropic money between community-based development and other activities, and second, to understand why foundations chose to distribute their monies in that way. The core committee of WGN went over the proposal and made recommendations on both the issues Randy was addressing and how to conduct the research. We also worked with members of three large foundations with Toledo offices, who educated Randy in the philanthropic culture of Toledo and who helped him gain access to insider information.

Aside from those foundation officials who had already begun to participate in WGN, however, the foundations refused to participate in the design of the study and refused to be interviewed. CBDO members helped to design the interview guide in order to elicit the information which would be most helpful to them, but the research "subjects" simply refused to participate.

Even with these problems, however, the research yielded information which could be used to the advantage of CBDOs. While it was clear that Toledo foundations gave very little money to Toledo CBDOs, it was also clear that they gave large sums of money to similar social service organizations, and to the United Way to distribute to other social service organizations. Thus, the research results not only provided hope that CBDOs might increase their share of the funding pie, it also supported the creation of a "coordinated appeal" funding model, which the funding model subgroup had begun to work on. It became clear from Randy's conversations with the few foundation officials with whom he was able to speak that foundations were reluctant to fund risky activities and were often unable to determine that risk. A United Way type of organization helped to reduce the risk. Thus, the creation of a coordinated appeal for CBDOs would reduce their "riskiness." As with the first research project, the results were distributed to elicit feedback on their usefulness and accuracy.

The second annual WGN conference, in June of 1990, brought together the work of these subgroups in a powerful pitch for increased funding for Toledo CBDOs. Shortly before the conference, we had received word that we were likely to receive nearly $500,000 from the federal government, which would be matched with $100,000 in local money and $150,000 from the national LISC, to create a pool to provide operating budget support to Toledo CBDOs. The conference then came to be as much a celebration as a push for change. A central part of the conference was a presentation of the research results from the foundation study, though this latest round of research did not create the immediate action that the first round did. The conference also, finally, provided a chance to focus and evaluate the group's efforts over the past year, and to begin discussions of an evaluation/goal-setting process that would begin in the fall of 1990.

So what have we to show for our efforts? first, we have been able to create an issue for participatory action research and have made some progress toward solving that issue. By focusing on the lack of funds available to CBDOs, we have been able to increase the flow of resources to community-based development. WGN has created the "Toledo Fund for Neighborhood Development," which assures multi-year funding for at least some of Toledo's CBDOs. The training program uses these resources and will hopefully also generate resources in terms of greater skills for CBDO members. The development of a funding model, and the availability of research to support it has provided room for the involvement of both the federal government and local foundations to provide potentially large sums of money to fund the Toledo CBDOs.

Secondly, the recommendation that CBDOs need to work together has been realized in three joint projects. In one case, three existing neighborhoods have combined to form their own CBDO. In another case, two existing CBDOs—one emphasizing advocacy and another emphasizing development—have combined their talents in a housing rehabilitation program. In a third case, two adjoining organizations have begun to discuss the possibility of developing some joint projects to maximize the use of staff talents. The original research project, and the strategy for carrying the results into practice, then, have set into motion a variety of projects, given them guidance and goals, and generated subsequent projects.

Activist and Academic Roles in the Toledo CBDO Project

This project is an effective example of participatory action research. The original research was generated out of community-defined needs, hav-

ing grown from a "Community Research Agenda" compiled by Dave Beckwith with the assistance of local organizers, was designed and carried out with researcher-community collaboration, and has been used by community activists. The degree of involvement by individual CBDO activists has varied tremendously throughout this process. A core group of five or six took this project very seriously, but others lacked either knowledge of the research process or trust that the research would help them. The second research activity—the foundation study—also fit the participatory action research model. Because the foundation study was an attempt to expose the barriers to funding CBDOs, it was partly "adversarial research" (Brown & Tandon, 1983), attempting to expose the structural sources of the problems which CBDOs faced.

The interesting aspect of this participatory action research project has been the relationship between the main researcher, Randy, and the main organizer, Dave. We have practiced a sharp division of roles throughout this process. This has been due partly to the hectic pace of each of our lives and partly to our different skills and backgrounds. Dave has been participating in community organization in Toledo for many years, and does not have formal training in social research. Randy has well-developed research skills, but is a newcomer to Toledo and has very little community organization experience. In some ways, then, Dave has provided the motivation and guidance for the project, while Randy has provided the technical expertise and the labor for the research projects which Dave has used as a basis for organizing the CBDOs. What are the benefits and difficulties of dividing the labor of researching and organizing, and how does this division provide solutions to the issues of gaining community legitimacy for the research and maintaining a community-based decision-making process?

One benefit of this division of labor is that it is efficient and practical. For each of us to do the other's tasks as well would require much more time and energy, and would probably produce many more mistakes. Neither one of us would be able to accomplish this entire project ourselves, since both the research aspects and the organizing aspects are very time consuming. It is unlikely that Randy would have still been able to engage in this research at all without Dave's sponsorship. Dave may have been able to organize the CBDOs, but would have lacked an understanding of the issues, and the effect that academic research has in legitimizing the issues.

Another advantage of this division of labor is that it protects the legitimacy of both of our roles. Randy's work is perceived as "objective" and "scholarly" partly because Randy is not seen as pushing an agenda. Dave can organize around the issues generated by the research without being

strongly associated with the creation of the research findings. This was especially true in the first round of research, which painted such a grim picture of Toledo CBDOs. Dave did not have to deal with accusations of having generated an agenda, and could be seen as responding to issues generated by others.

Finally, perhaps the most important advantage of our division of labor is that it reduced the role ambiguity for both of us. Randy could avoid the difficulties associated with an outsider pushing an agenda and undermining community control. The problems of evaluating potential action strategies (Jason, et al., 1988), overcoming community distrust (Jason, et al., 1988; Kelly, 1979; Kelly, Muñoz, & Snowden, 1979), and advocating community positions (Favero, 1987) are reduced by having local activist sponsorship of participatory action research.

Overall, then, our role separation has allowed us to successfully avoid a number of dilemmas a single individual occupying both the organizer and the researcher roles would have faced. But this division of labor also creates two disadvantages. First, both the organizing and research activities have been in our hands. We originally prioritized issues, and defined the most effective process for resolving those issues. The research framed the issues, and ultimately emphasized that before CBDOs could accomplish anything substantial they needed to drastically improve funding. The WGN subcommittee structure reflects the issues framed by the research. Randy worked hard to make sure that the first round of research reflected the input and needs of community members, and Dave worked hard to make sure the subsequent organization reflected the issues raised by the research findings, but the actual work of creating the research findings and organizing around those findings remained primarily in our hands. It has been encouraging, however, that the funding model subgroup created a model for funding Toledo CBDOs without much intervention from either Dave or Randy. And the second year of WGN, begun with a goal-setting retreat, decentralized influence even further and revived WGN membership involvement.

Another disadvantage is that our present division of labor inhibits the development of critical theorizing. Randy's academic perspective is informed by neo-Marxist urban theory and social movements theory. While Dave's organizing perspective reflects those theories, he is much more interested in the practical Alinsky-type concerns of redistributing power to communities than in exploring and employing grand theory. In organizing the CBDOs, then, Dave's perspective has prevailed, and probably for good reason, since it is unlikely that attempting to employ more critical abstract academic theory would yield any results. Toledo CBDO members do not operate from a radical world view and are much more focused on solving

their immediate problems, making them unlikely to be sympathetic to a critical theorizing process.

Conclusion

Even though there is a long road to travel to create effective community-based development organizing, we are still hopeful about the role to be played by action research. There is a continuing commitment among a healthy core of Toledo's CBDOs to make this process work. People are continuing to show up for meetings, they are accomplishing the activities which they have agreed to take responsibility for, and every mass meeting of WGN shows clear steps toward meeting the groups' goals. There are occasional difficulties in getting subcommittees to meet, or making sure that subcommittee representation is not skewed against CBDOs or certain kinds of neighborhoods, but there is a continuing sensitivity to those issues by WGN members, and ready accommodation.

Our experience with this process shows that there are no formulas to follow in designing and carrying out participatory action research, and all the guidance of community development experts must be qualified. Favero's (1987) fear that the professional who acts as an advocate might disempower communities is well founded. Yet, if Dave and Randy had not acted as advocates in the initial organization of WGN, the group would likely not have formed. Snowden, Munoz, and Kelly's (1979) and Voth's (1979) emphasis on organizing action research around community needs is also important. Yet, had we not set out on our own in choosing one of the community-generated research projects and its dimensions, there would be no WGN. Indeed, Dave's response to this problem is that "my job as an organizer has always been to push, to prod, to suggest, to test out, to listen actively, to pressure folks to move rather than talk—not to decide for them but to make sure they decide!" The community agenda is created through the mutual involvement of the researcher, the organizer, and the community—it can be no other way. The very act of research will necessarily highlight certain issues, and which issues are to be highlighted are necessarily affected by the research design, which, in turn, is necessarily affected by the researcher.

Ultimately, there is a role for researchers to play in showcasing and publicizing needs within communities, similar to projects in Lansing, Michigan (Truman, et al., 1985) and Sac City, Iowa (Goudy & Tait, 1979). In these projects, however, there was clear initial sponsorship by community organizations and/or leaders. In our case, there was initial support of only a

few CBDO organizers which we then had to further develop. We can, then, conduct descriptive research to show communities that they have needs and that possibilities exist for change. It would be presumptuous of us to prioritize those needs, or to propose solutions, since that is the community's task. But researchers' reluctance to provide even a forum for citizens' needs to be made visible often contributes to inaction and continuing difficulties.

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Techniques for Imparting Clinical Knowledge in Nonclinical Courses

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Introduction

One of the major difficulties in teaching sociology in applied areas is the imparting of clinical information in courses which are not designed for clinical training. In courses focusing on topics such as gerontology, family violence, or other marital problems, sociologists may often want to impart information which is derived from clinical cases. Indeed, it may be impossible to cover these topics adequately without providing information which is obtained largely in clinical settings. Frequently, however, the courses in which these topics are covered do not include a clinical component. Consequently, there is no opportunity for the instructor to suggest a series of clinical characteristics for students to observe. Lacking access to such experiences, what techniques can sociologists employ to enliven the understanding of factors which play important roles in clinically observed problems? This paper suggests techniques for bringing clinical experience into the typical classroom by means of detailed classroom examples and the students' own personal experience, in lieu of a clinical component to the course.

As an example, I will use the topic of elder abuse, which is included in several of my classes in both gerontology and family violence. These courses include a wide variety of students, both graduate and undergraduate, with many different majors, from sociology and psychology to nursing, social work, and education. Some students, particularly those in social work and nursing, have had clinical experience; most have not. In each instance, the course requires that a broad spectrum of material be covered, leaving little time or opportunity for clinical materials to be presented. In the area of elder abuse alone, for example, it is essential to cover several different dimensions of the problem, including the definition and types of abuse, the likely frequency of the various types of abuse, suggested theoretical explanations, and the techniques and problems of researching the issue, to mention a few (Galbraith, 1986; Hickey & Douglass, 1981; Pagelow, 1984; Pillemer & Finkelhor, 1988; Sengstock & Liang, 1983).

Clinical Components

In order to comprehend the sociological and social psychological aspects of elder abuse, simple recognition of definitions, types, and frequencies is inadequate. Students must also understand the situational and background factors which engender abuse and the interrelations which exist within abusive families, as well as the societal and political factors (Medicare requirements, for example) which may exacerbate the problem. An understanding of the complex dynamics of the interrelation of these varied factors within a specific situation requires knowledge of specific individual cases, however. It is also important that students, particularly those who may work with elder or abusive families, begin to develop empathy for both sides of the issue. This unique, individual component, an understanding of the manner in which sociological and social psychological factors interact within a given situation, is what can be provided by a clinical experience. How can we provide this opportunity to students when clinical applications are impossible? I will suggest some techniques for accomplishing this goal.

Techniques for Imparting Materials

It is easier for students to develop a recognition of these issues if they have direct contact with clients. Lacking this opportunity, however, a semblance of clinical experience can be obtained by providing a series of

extended clinical illustrations. The first component of such a teaching method is the use of case histories to illustrate various types of elder abuse and important related factors. These case histories can be obtained from previous research, from clinical cases observed by the instructor, or from examples provided by students themselves, either in this or in previous classes. They can be provided in written form prior to the lecture or in oral form during the lecture and discussion.

Probably the most important factor in this teaching method is the provision of sufficient detail, such that the cases and their participants "come alive" for the students. Lacking direct contact with the individuals involved, students may be able to develop a better understanding of the problem if the instructor, like a good novelist, can enable them to "feel" that they know these individuals.

Two types of elder abuse which are particularly difficult to explain are material abuse and the violation of an elder's personal rights. Many people consider these to be relatively minor issues, since they associate "abuse" primarily with direct physical assault. They understand the dimensions of the problem much more effectively once they are provided with details of a case in which a son systematically defrauded his fully competent, 80 year old widowed father of nearly $100,000, and then attempted to prevent him from remarrying because he feared the loss of his inheritance. Only a lawyer's intervention halted the son's controlling behavior.

It is also often difficult for students to understand the demands of 24 hour care of an elderly patient on the caregiver. This lack of understanding can lead to a failure to comprehend the factors which can contribute to abuse. Only by describing, in some detail, the demands of 24 hour care can this lack of comprehension be overcome. Students need to realize that dependent elderly patients cannot be left alone for even half an hour and that opportunities for respite are often not available. They need to understand that the duties may even include such difficult tasks as changing an elderly parent's diapers, in spite of a life long taboo against seeing one's parents naked. Personalities of elderly patients may be altered such that a beloved aged parent may become combative or may no longer recognize his/her own spouse or child. Only through extended case descriptions can students begin to comprehend the distress to family members faced with extended care under such conditions.

Analogy to Personal Experience

It is extremely helpful to provide students with analogies which can enable them to compare their own personal experiences with those of elderly victims and/or their families. Most have never experienced life in a three generation household. They can begin to understand some of the problems, however, if reminded of the difficulties of adjusting to the life style of others in similar settings: new roommates, newly married couples, or parents encountering the developing independence of their teenage children. And anyone who has had small children can comprehend the difficulties of 24 hour care of a relentlessly demanding infant. Yet elder care is even more frustrating, since elderly patients, unlike children, become ever more dependent.

Encourage Participation

Finally, students increase their understanding if they become involved in the class discussion. Consequently, they should be encouraged to contribute their opinions in a variety of ways. This may include questions about the cases presented: Have they ever been in similar circumstances? How did they feel? Can they draw an analogy to the elderly victim? To the caregiver? Students may also be encouraged to provide their own examples. Some may have clinical experiences to relate. Others, particularly older students, may themselves have elderly parents or grandparents, and may have observed firsthand the difficulties of providing care. Their experiences may be used to enrich the understanding of their classmates.

Finally: A Note of Caution

Courses which focus on practical issues, such as family violence, marital problems, or care of the elderly often attract special types of students. Ideally, these will include students whose future professional goals involve assistance to the types of clients whose problems are discussed. They may, however, also include students whose personal lives are currently troubled by similar difficulties. Some may take the course specifically because it focuses on their personal problems; others may only become aware of their own latent personal problems as the topic of the course unfolds.

In either event, the encounter provides an opportunity and a challenge to the clinical sociologist. Many of these students should be in therapy; this

course may be the first step in that direction for some of them. The clinical sociologist, as instructor, can help to guide them in that direction. At the same time, however, they must be prevented from disrupting the remainder of the class by seeking undue attention to their own personal problems. Some individual attention on the part of the instructor to these students may be necessary to assist them without distracting the attention of the class as a whole.

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Theater As a Teaching Procedure in Sociology

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Introduction

For the past several years, the Department of Sociology, University of Brasilia (UnB) has used theater as a pedagogical tool for teaching sociology. The results have been encouraging with respect to both the participants' increased sociological understanding and their personal growth. The purpose of this paper is to present some of the ideas regarding the use of theater as a teaching tool and some of the procedural steps.

The use of theater as a method of teaching sociology began in 1985 as an endeavor to motivate undergraduate sociology students who were taking a course in the Sociology of Labor. At that time, the Department of Artistic Education at UnB initiated a special project with the suggestive title of "Commit your Scenes."[1] Within this project, any Department or student at the university could perform a scene or dance in an improvised showroom at the Art Department on scheduled days.

*An earlier version of this paper was presented at the International Sociological Association meeting, Clinical Sociology Session, Madrid, Spain, July 1990.

I had twenty-three students enrolled in my course on the Sociology of Labor, and it was not difficult to convince twelve of them that they should prepare a presentation for that semester. One of the components of Sociology of Labor was the ideology of work. Such topics as moral asceticism, the right to be lazy, and the creative side of idleness were fully discussed through the readings of classic works by Weber, Lafargue, and Marcuse.[2] We chose to stage an act of "The Farce of Good Laziness," by Brazilian playwright Ariano Suassuna,[3] since this play presented all of these topics in a very sarcastic, Dionysian, and poetic way. The play itself is a eulogy of a more poetic and pleasurable way of life, based on folktales of the Brazilian Northeast, in which the praise of idle and creative heroes is quite frequent.

After receiving successful feedback, an attempt was made to stage a second play the next year. At this time (1986), the course was on the Sociology of Education, and "The Daybreak of My Life,"[4] by Brazilian playwright Naum Alves de Souza was selected. I had nineteen students enrolled in the course, twelve of whom actually participated in the staging. The others continued with their regular academic work. The third play was "A Respectable Wedding," by Bertolt Brecht, which was staged during a course on the Sociology of the Family and, this time (1987), all enrolled students decided to participate in the theatrical experience.

By 1988 our "Theatre as Teaching Procedure in Society" project had become an extension program which permitted students from other areas and schools to participate in the staging of "The Three-Penny Opera" by Brecht. The idea was to use a critical approach to the themes of corruption and impunity as part of a Political Sociology course.

Our last experience (April of 1990) was a presentation of the Brazilian play, "The More-or-Less Holy War," by Mario Brasini[5] which depicts the relationships between the Church, local politics, and sexual morals in a small town in the Brazilian backlands. This was staged with the participation of undergraduate students taking the Sociology of Religion, as well as students of other subjects since the project was now a regular extension program.

The remainder of this paper presents some ideas related to the process of staging the plays, including the selection of the text, discussion of its contents and characters, and the theoretical and psychological preparation of students. It also deals with the relationships between the regular courses during which the experiences were conducted and the sociological inferences made from selected plays. Finally, some comments are made regarding the development and personal growth of the involved students.

The Process of Staging

Selecting the play is probably the most complicated part of the whole process. This is so because the chosen play must meet at least two conditions. First, there is the appropriateness of the theme of the play with respect to the topics and concepts dealt with in the particular course. Secondly, the selected play must excite the curiosity of the students and must also raise my personal interest in staging it. Since the students normally do not have much information on theatrical plays, this selection is done almost exclusively by me and the artistic director.[6] finding a play with enough sociological content to justify its choice requires a lot of research. Furthermore, the play must be simple enough to permit its staging with limited resources. Finding such a play which also has the capacity to raise my and the students' interest and curiosity becomes very difficult. If a suitable play is not available for the exploration of the intended thematic, the idea is postponed for another occasion. This has happened many times. Most of the time the choice has become a matter of good luck, and it is not an easy one, as might be imagined.

Before rehearsals begin, a series of discussions of theoretical texts related to specific topics contained in the course programs are conducted. For instance "The Daybreak of My Life" deals with elementary school conflicts and children's cruelty. Thus, before starting rehearsals for this production, a series of seminar discussions on Freud's papers about children's sexuality[7] were conducted.

In addition to the theoretical preparation of students, these discussions are also designed to emotionally prepare the students to participate in the theatrical experience, since most of them do not realize what is involved in the process of acting, character creation, staging design, and so on.

This method of preparation has two results. First, the students become more perceptive of the contents of the plays, thus promoting their understanding of the characters they are to perform. Secondly, when the rehearsals actually start, the students are relaxed and confident enough to overcome their inhibitions and their fear of being ridiculous.

The process outlined above has been applied in successive experiences, always with many positive results. Sometimes, these resluts have gone far beyond the classroom. In the case of "The Three-Penny Opera," further discussion of the themes of the play occurred in newspaper articles and non-academic works, for the topics of immorality and impunity had become frequent subjects of daily news in Brazil at that time. In our last experience, systematic and comparative readings of Freud's and Durkheim's main works on religion and morality,[8] were carried out.

Teaching Sociology

Participation in theater has provided my students with a variety of experiences with sociological topics and concepts. As mentioned, the first theater experience focused on labor and toil. In the second experience, carried out during a regular Sociology of Education course, the focus moved from the field of labor or toil to the arena of schoolroom situations, and to the social relations established between children and their teachers and parents. The myth of the happy childhood and the repressive character of school assignments were shown as they were reflected in the introjection of the authoritarian personality and social norms by school children.

"The Respectable Wedding," by Brecht, attempted to present the family at its moment of constituency through the experimentation of a critical theory about socialization and the fulfillment of predictable social roles. The criticism also aimed at family members in their compulsory and prevalent hypocrisy. The idea was to turn each audience member into a social scientist, like Galileo, who used to examine the stars at a distance with his telescope.

The intent of "The Three-Penny Opera" was to unveil the tragedy of London's lupenproletariat of 1928, together with Brecht's scorn for the business world, religious hypocrisy, romantic love, and the venality of law, in a historical moment of corruption and discredit of the authorities. The play presented a similar context to that which Brazil was facing in the late 1980s. It also attempted to make the audience laugh about their own absurd anomie by following Brecht's suggestion that laughing is criticizing, and that seeing from a distance is focusing, in historical terms. The play attempted to show that Brazilian social order was composed of individuals who faced ethical principles, not to follow them, but to infringe upon them, leaving ethic morality as an object of mockery. This meant that citizens were slowly becoming superfluous social beings, with a tendency toward arrogant delinquency and blatant violence.

Finally, in the "The More-or-Less Holy War," we presented the saga of a priest who, wanting to close the brothels of his parish in a year of county elections, had to dispute the political hegemony with both the most affluent local "madam" and the richest landowner. The themes of religious indoctrination, sexual relief and political collusion were fully explored. The play attempted to demonstrate that, at least in the field of official politics, matters have not changed much in Brazil, as the priest's moral crusade—on which the play was based—actually happened in 1962.

The students not only acquire further comprehension about the sociological aspects which appear in the text and in the characterization of their

own roles, but, in addition, the compositions of the scenes as social gatherings offer the students the possibility of becoming actors in predetermined social settings.

This experience is made possible through a careful aesthetic approach which is developed by the artistic director. This approach also provides intense sociological background to the artistic work. Thus, the artistic director teaches students the techniques of walking, dance, song, and speech, and is benefitted in return by the sociological information furnished by the students. The main result has been, in many cases, a reduction of the interpretative work which would have had to be done by the artistic director. In this way, the sociological background actually facilitates the artistic work. In some cases, this has resulted in very shy students—those who rarely talk in the classroom—becoming good actors and performers.

Personal Growth and Development

The students themselves provide lively examples of personal growth. I have collected several statements by students who say that after their theatrical experience, the art of rhetoric became an "easy matter" for them. This result may again be ascribed to the aesthetic dimension in its therapeutic capacity as an agent of sublimation.

The theatrical experience has also provided the basis for the development of a new concept of collective work on the part of the students. A new sense of cooperation, solidarity, and companionship is gained upon this experience. By the very nature of theater, students come to understand their complete dependence on their mates, technicians, hair dressers, costume makers, and so on. At the same time, the theater promotes the students' familiarity with the sociological problems and categories focused upon in each staged play.

In addition to these positive developments, students have provided evidence of how their involvement in the groupings facilitated their own integration in the University. They affirm that "after the theater" they started to appraise the university in a more positive way. This happened only after they had been seen on stage by hundreds of people. Some have stated that their participation in the play was an excellent opportunity for making friends in "the cold atmosphere" of Brasilia.

Conclusion

Regarding the sociological content required in each course program, any appraisal at this point would be premature. It must be remembered, however, that these experiences were offered as optional academic subjects. What has frequently occurred is that, instead of requesting additional theoretical discussion post festum, the students concerned have praised the stagings as an opportunity to do something "more pleasurable and different." However, I have noticed that the writing, thinking and sociological expression of some have become more fluent, and this may become a major asset in their professional formation.

I believe that a reasonable evaluation of the use of theater as a teaching procedure must follow at least two directions. First, an evaluation should consider the impact of the theater experience with respect to the theoretical concepts and academic criticism provided by the selected readings and by the play itself. This would take into account the long sessions of discussions, before, during, and after the rehearsals, as well as in the classroom. Secondly, an evaluation should also deal with the socializing aspects of the theatrical experience, since it involves the participation of youngsters during four to six months, sometimes on an almost daily basis.

NOTES

1. "Cometa Cenas," in Portuguese.
2. More specifically, *The Protestant Ethic and the Spirit of Capitalism* (1932); *The Right to be Lazy* (1907); and *Eros and Civilization* (1956), respectively.
3. "Farsa da Boa Preguica," in Portuguese.
4. "A Aurora da Minha Vida," in Portuguese.
5. "A Guerra Mais ou Menos Santa," in Portuguese.
6. Later on, we will comment on his role in the process.
7. Especially *Three Essays on the Theory of Sexuality* (1905) and *"Civilized" Sexual Morality and Modern Nervous Illness* (1908).
8. Especially, *Totem and Taboo* (1912-1913) and *The Elementary Forms of the Religious Life* (1912), respectively.

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Book Reviews

Handbook of Clinical Sociology, edited by Howard M. Rebach and John G. Bruhn. New York: Plenum Press, 1991. 434 pp., $55.00, $29.50, paper.

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This handbook is long overdue. It is a book which will assist those involved with clinical practice (read problem solving) as well as those in academia who are interested in gaining a better understanding of a rapidly emerging discipline.

The book is broken down into four major parts. Part one is entitled "The Emerging Field of Clinical Sociology," and provides a definition of the field as well as a discussion of the place of clinical sociology in America. Part two is focused on "General Practice Concerns." These include the issues of assessment, intervention, program evaluation, relationships with clients, ethics, and the effects of social change on clinical practice. Part three deals with "Clinical Sociology in Specific Settings," and gives examples by actual practitioners. Included in Part three are detailed discussions of individuals and families, public policies, medical settings, health promotion, mental health, criminal justice systems, mediation, organizational development, the workplace, and interventions in school settings. Part four is devoted to "Special Populations." These special populations include the mental health setting, empowerment of women, gerontology, and drug abuse prevention.

This large volume is well organized. It certainly meets the goals of providing the reader with an overview of the field and a detailed discussion of the hands-on work that sociologists are currently performing. It does not include the clinical sociologist in some settings, such as the military or specific work set-

tings (although there is a chapter by Arthur Shostak on issues in the work place in general).

The historical material in the beginning provides the reader with a good understanding of clinical sociology's long history in the United States. The reader clearly comes to understand that clinical sociologists are interventionists. In reading the book, one learns that sociologists are problem solvers in the true sense. One of the more positive features of the book is its attention to ethical issues.

I remember speaking with Dr.. Rebach when he was in the formulation stage of the handbook. I am aware of the great difficulty that he had in wrestling with such issues as: What fields are to be included or excluded? How much descriptive text versus problem solving presentations should there be? What is the relationship between theory and practice? These and a host of other issues are always difficult for organizers of handbooks. However, it must be noted that the editors have, by and large, succeeded in a fair balance.

This is the kind of book that college professors who teach courses on clinical sociology, sociological practice, social change, social intervention strategies, sociology of work, and related themes will find extremely useful. There are areas that could be strengthened in future editions. First, the book could use a summary statement by the editors in order to bring together the diversity of settings and techniques presented by the applied sociologists, and a summary of the patterns of application, relevant theories, and future areas of sociological intervention. Secondly, the book appears to be somewhat weak in its coverage of theoretical aspects. This need not be a criticism if one understands that an initial handbook has, as its purpose, the presentation of the problems, settings, and solutions. However, clinical sociology has been criticized (usually by non-applied sociologists) as being divorced from theory.

It is my experience that this criticism is invalid because most clinical sociologists have a particular theoretical orientation or orientations. However, the book might play into the hands of some who would argue that applied sociology is non-theoretical. Most sociologists are schooled enough in mid-range theories to use them as their regular basis of expansion, understanding, prediction, and integration of diverse observations. There is some attention to this in the handbook, but probably not enough.

The book reveals a very interesting and obvious fact concerning the contemporary social sciences—that sociology, as a discipline, has effective interventions to pressing contemporary problems that are substantively different than those of other disciplines. One need only read the chapter on mental health and clinical sociology by Ferguson to understand how true this is. By employing a bio-psycho-social role theory of mental health, the authors are able to impress

us with the utility of an interdisciplinary model (especially with the clinical sociologist serving as a member of the clinical team).

There is an old saying in the field that sociology is what sociologists do. There is much truth to this, but until recently the diversity of the fields of involvement of sociologists was unknown (not only to the public, but to other sociologists) about the expanding boundaries of their own discipline. One of the major complaints that professors often hear from students (if they are open to listening) is that the professors, themselves, are not aware of the diversity of occupational/professional involvements within their discipline. The idea that sociologists can only teach or do research is a myopic view. Students are increasingly asking for more career-line opportunities. They do exist and this book reveals some of the niches. Professors who are not involved in (nor necessarily interested in) clinical sociology should read the handbook in order to enhance their role of advisor to their students about the broadening opportunities within their own discipline.

Clinical Intervention for Bereaved Children: A Hospice Model, by Elizabeth J. Clark, Grace C. Zambelli, Anne de Jong, and Karen Marse. Montclair, NJ: The Hospice, Inc, 1988. 102 pp., $29.50

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This is a manual on bereavement intervention prepared by staff members of The Hospice, Inc. of Montclair, New Jersey for use by hospital and hospice personnel. In the authors' view, the patient and family, in the face of death, constitute a single unit of care. Effective intervention on behalf of grieving survivors, they propose, can best be realized through the social support of families after, as well as prior to, a death. In keeping with this perspective, they describe an ongoing Bereavement Intervention Program instituted at the Montclair Hospice in 1985 involving both children and parents that, they believe, can serve as a model for other practitioners. The program includes a Creative Arts Therapy Group for children and a Companion Bereavement Support Group for parents. Typically, the two groups meet weekly, for one hour, over a ten-week period. They meet separately, except for two group sessions when they are brought together to review their progress and to facilitate dialogue between parent and child. While a formal evaluation of the program is yet to be completed, the authors report that most families describe themselves as more competent to deal with the death and more understanding of their child's reaction to loss after having participated in the program.

The manual is divided into two parts. The first part discusses the issue of childhood bereavement and briefly reviews the contemporary literature on chil-

dren's grief and its treatment. The second part addresses the task of developing and implementing an intervention program and considers such issues as: advertising and recruitment; facilities; initial interviews with families; grief assessment instruments and therapeutic tools; activities lists for childrens' and parents' groups; progress notes; evaluation of groups and program; and funding and reimbursement. The bibliography includes not only relevant literature on grief and bereavement, but also items pertinent to the use of art therapy for children burdened with loss. An appendix contains examples of the different materials used in the Program.

This manual has the potential to serve its intended audience well. It is, however, burdened by serious flaws. First, it needs careful editing. The far too numerous errors in grammar, spelling, and syntax seriously distract the reader and interfere with the message that the authors wish to convey. One begins to lose faith when a book written by instructors on death and dying misspells the word cemetery—shades of Stephen King. Secondly, the manual is seriously bloated—thirty of its 102 pages are blank, for what purpose the authors do not say. This inflation of the text, the reviewer suspects, would also inflate the cost of its publication, and further detracts from what would otherwise be a useful resource manual.

Space does not permit the discussion of the important questions that a bereavement intervention program raises for the health care practitioner. The reviewer would hope that in the next edition of the manual such issues as the ethics and utility of grief intervention, the importance of a professionally trained staff, or the reliability of different therapeutic tools will be addressed. As the manual now stands it falls short of its laudable goal.

Be an Outrageous Older Woman—A RASP*—*Remarkable Aging Smart Person, By Ruth Harriet Jacobs, Manchester, Connecticut: Knowledge, Ideas, and Trends, Inc. Publisher, 1991. 206 pp., $14.95, paper.

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Question—What do Ruth Harriet Jacobs and Alan M. Dershowitz have in common? Answer—Both wrote about a group suffering from second-class-citizenitis, and both prescribed the same cure: large doses of "chutzpah."

In his recent book, *Chutzpah*, Alan Dershowitz suggests that as Jews, "deep down we see ourselves as second-class citizens—as guests in another person's land." We have therefore tried not to offend our hosts by looking or acting too Jewish. Instead we have flattered them with attempts to disguise our Jewishness

behind a facade of Anglophilia. In many cases, Dershowitz notes, Jews afflicted with Anglophilia looked like they were probably wearing tweed underpants beneath their British-tailored slacks. And they did not merely dress British—they thought British too. Their Anglophilia affected their mannerisms, attitudes, speech, and even their choice of jokes. This aesthetic mimicry is symptomatic of an internalized anti-semitic aesthetic. It is fueled by a longing for acceptance by the "real" Americans.

The good news is that, according to Dershowitz, the time has passed for these feelings of marginality—of being outsiders seeking acceptance. The time has come for a new boldness, assertiveness, willingness to demand what is due, to defy tradition, to challenge authority, to raise eyebrows—to show some chutzpah in the best sense of the word.

In *Be An Outrageous Older Woman,* Ruth Harriet Jacobs tackles a similar problem, albeit with respect to a different population. Her focus is on the internalized negative imagery of older women in the United States today. She too challenges the desperate attempts to pass, this time for a younger woman rather than for a WASP. She too perceives such attempts as complicity in the stereotypic assumptions of the unattractiveness and marginality of the group. And she too challenges her readers to demand what is due them, defy tradition, challenge authority, raise eyebrows—to be a little outrageous and show some chutzpah!

This is a daunting challenge in an ageist culture which consistently bombards women with strategies for passing—Oil of Olay for starters, cosmetic surgery a little later. It is commonplace to overhear someone being told flatteringly, "You look so young for your age." This is offered as a compliment, and the anticipated response is "Thank you." In fact, this is not a compliment but an ageist insult. When a well-meaning black friend paid me this "compliment," I asked her if she would be flattered if I told her admiringly that she was so light she could pass for white.

Ruth Jacobs not only challenges her readers to demand what is due them. She also provides creative ideas for enjoying life as an outrageous older woman who knows who she is, what she wants, and how to get it. Whether the issues relate to political activity, sexuality, identity, friendships, relationships with descendents, housing, money, bereavement, work, creativity, dress, or just having fun, there is a provocative chapter on the issue—with anecdotes demonstrating that chutzpah works!

The author has written a book which addresses older women across the spectrum of social class. She has incorporated information regarding low cost lunches at Senior Centers along with information on retreats for professional artists and writers. Consequently, no single reader will find everything of interest. Nevertheless, all readers will discover sufficient precious bits of useful information, insights, and inspiration to make it well worth the effort. It is a

wise, witty, and chutzpadic attack on a tough problem and I highly recommend it to my colleagues, clients, and friends.

Violent Emotions: Shame and Rage in Marital Quarrels, by Suzanne M. Retzinger. Newbury Park, CA: Sage Publications, 1988. 238 pp., $19.95, paper and **Psychiatric Response to Family Violence: Identifying and Confronting Neglected Danger**, by Edward W. Gondolf. Lexington: D.C. Heath and Company, 1990. 280 pp., $34.95

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For the practicing sociologist, especially those interested in individual and family issues, there is good news and better news about these two books. The good news is that both books are useful and can be read with great profit by the student of medical sociology research. The better news is that one of the books is outstanding and is useful to the *practicing* sociologist.

Both books are written by sociologists interested in mental health and both deal with the timely topics of violent behavior and emotional interaction at the level of the family and other small groups. Each attempts to present both a theoretical statement and an empirical evaluation of the theory based on close scrutiny of several case studies. It is at this point that the quality of the two books begins to diverge for the practicing sociologist. Retzinger's book makes a greater contribution to the field of sociological practice by offering information and making direct suggestions that can be translated readily into intervention tactics, especially for the counseling sociologist. Gondolf's book, on the other hand, maintains a traditional sociological perspective and is solid medical sociology research. It is perhaps most useful as a subtext in a graduate-level mental health class.

Retzinger's book is a microtheory about the connection of the emotions of shame and anger in individuals' response to today's world. Her thesis is that people respond to a constant threat of the loss of an important social bond with the emotion of shame. The word shame is of growing significance among mental health professionals today. A number of books have been written in the last few years on the subject. (See Bradshaw, *Healing the Shame That Binds You;* Fossom and Mason, Facing Shame: *Families in Recovery;* and Kitchens, *Understanding and Treating Codependence* as examples.)

In these books, shame is defined simply as the sense of personal inadequacy and lack of personal worth. Most of these researchers argue that shame arises from the fear of abandonment in the family of origin. Retzinger shows the sociological significance of these arguments. As Retzinger sees it, the fear of alien-

ation from the group or the loss of a significant social bond produces the feeling of shame as an ongoing process of life.

Retzinger's goal is a theory of conflict founded on her concept of shame. She builds on the traditional theories of Durkheim, Marx, and Cooley, among others, and incorporates the more modern-day theories of family systems and other therapeutic methods. Her argument is that conflict—or anger, violence, or rage, as she calls it—is a natural and spontaneous response in the individual when the emotion of shame is left unattended. Shame, she argues, is the emotional signal of an impaired social bond and, if left unacknowledged, escalates from anger to rage in a self-perpetuating cycle. The main ingredients of her theory are:

1) An important social bond is threatened in the individual's life, often with disrespect for the worth of the person.

2) The individual experiences shame, which is a signal of the disrupting of the system.

3) Shame is not acknowledged and the self feels alienated and attacked.

4) Anger follows as a protest against the threat and as a mechanism for saving face. Depending on the importance of the bond, the anger may be small and short-lived or it may be long-lasting and severe. Retzinger reminds us that people kill for social reasons, like lost affection and lost honor.

After meticulously illustrating her ideas from four case analyses, Retzinger concludes her book with a helpful section on rebuilding the broken bonds. It is at this point that the book becomes a study in sociological practice. Knowing what shame and anger are and where they come from, the question for the practitioner becomes: What can we do? Retzinger's suggestions are succinct and are drawn from literature on communications and from theories of symbolic interactionism. It is unfortunate that her suggestions are so brief. Perhaps sociologists are not yet convinced that their theories can be applied to real live human situations and that problem-solving tactics can be developed from them. At any rate, Retzinger opens the door to the application of her theories even if she herself is not able to step completely through the door. Opening it in such a decisive manner is perhaps contribution enough.

Gondolf's book is a carefully researched and well-written description of the limitations of psychiatric responses to family violence. These limitations include a lack of understanding of the difference in family and non-family perpetrators and of how victims of violence differ. Hospital staff often underinvestigate and minimize patient reports of violence, and frequently are unwilling to confront the violent behavior of perpetrators. Gondolf presents numerous cases to demonstrate these and other defects of the medical establishment's response to family violence. He concludes his book with several suggestions for changes that range from protocol in evaluation interviews to

institutional and legislative initiatives that will result in greater responsiveness to family violence.

Gondolf's book is a well thought out and researched documentation of the limitations of the medical response to violence in human interaction. His book's greatest contribution is to encourage changes at the policy-making level and in the training of medical professionals.

The Rich Get Richer: The Rise of Income Inequality in the United States and the World, by Denny Braun. Chicago: Nelson Hall Publishers,1991. 383 pp., $29.95, $19.95, paper

Assets and the Poor: a New American Welfare Policy, by Michael Sherraden. Armonk, NY: M.E. Sharpe, Inc., 1991. 324 pp., $34.95

Josephine Ruggiero and Eric Hirsch
Providence College, Rhode Island

Both of these books deal with the problem of economic inequality, but in very different ways. *The Rich Get Richer* is a broad analysis of recent trends in economic inequality and poverty rates in the U.S. and the world, while *Assets and the Poor* prescribes an alternative to the current welfare system in order to cure poverty in the U.S.

In his chapters on the U.S., Braun documents the oft-noted increase in inequality in the U.S. during the 1980s. He shows how basic features of our economic system—such as segmented labor markets, deindustrialization, and chief executive officer compensation programs—as well the Reagan administration's tax and spending policies created increased wealth and income disparity. The strength of the book is a review of the many potential costs associated with extreme inequality, including an increase in political violence, economic stagnation, a variety of social problems for working and middle-class families, and the increased willingness of the super rich to engage in risky investments. Thus Braun shows how the current banking and savings and loan debacle can be fruitfully viewed as a result of increasing income and wealth at the top of the U.S. class structure.

In chapters on inequality around the world, Braun again describes the severe inequality which has the top 1 percent of income recipients gaining 15 percent of world income while the poorest 20 percent get 1 percent (p. 49). He offers a fine critique of development theory by marshalling evidence that shows how investment by multinational corporations and loans by the International Monetary Fund actually lead to greater economic inequality. Multinational corporate investment leads to an initial increase in gross national product per person but slower economic growth in the long term due to the export of profits.

IMF loans increase inequality because IMF policy makers force reductions in government programs that assist the poor in order to facilitate debt repayment.

Braun's analysis is marred by a tendency to use lengthy quotes from other authors, an overuse of exclamation points, and a disorganized chapter on policy solutions to inequality. But this does not detract from the importance of his analysis of increasing economic inequality and its social costs.

If Braun defines the problem, Michael Sherraden, in *Assets and the Poor*, tries to articulate the solution. His thesis is that "asset accumulation and investment, rather than income and consumption, are the keys to leaving poverty" (p. 294). While income transfers provide for day-to-day needs, accumulation and investment have the potential to change the way people think and behave in the future. Welfare policy therefore ought to be redirected to recognize this fact.

In Part I of his two-part book, Sherraden argues that, unlike European nations, the U.S. is ambivalent about being a welfare state and consequently less generous with assistance and more judgmental about what the poor do with their welfare checks (Chapter 1). Still, he suggests there is a serious problem that must be solved: the rising proportion of children living in poverty (Chapter 2). His solution is to reduce the stigma associated with income transfers by emphasizing incentives which encourage asset accumulation by the poor (Chapter 4). This policy would eliminate the current ban against savings by welfare recipients; the poor, like the middle class, would be expected to have a mix of income from assets, employment, family sources, and the government.

In the last chapter in Part I, Sherraden concludes that ". . . none of the major viewpoints (conservative right, liberal middle, and radical left) pays attention to individually held assets of the poor" (p. 89). Although the left raises questions central to the asset accumulation notion—such as "Can capital really be redistributed under capitalism? Can a more democratic capitalism be achieved?" (p. 88)—their attention is wrongly focused on socially rather than individually controlled capital (Chapter 5).

In Part II, Sherraden explores the issues related to and the possible dimensions of an asset-based welfare policy. He explains why blacks have generally been less able than whites to accumulate assets and argues that many of the problems experienced by blacks will continue until they obtain a distribution of assets more equal to that of whites (Chapter 8).

Sherraden's asset-based approach to poverty policy utilizes IDAs (Individual Development Accounts), which work much like IRAs (Individual Retirement Accounts). Deposits would be linked to "positive" individual achievements which also benefit the nation as a whole; these could include completing grades in school ($500 per grade completed), graduating from high school ($2500), receiving job training, getting a job, or engaging in national service activities. Withdrawals from the IDA could be made only for designated reasons, such as

for the funding of a college education, and parents or guardians could pass on IDA funds to their children without penalty.

The program would be funded through a variety of tax increases, including full taxation of Social Security benefits, the removal of 50 percent of tax deferment for pension contributions to earnings, taxation of employer contributions to medical insurance premiums and other fringe benefits, the elimination of 50 percent of home mortgage interest deductions, the elimination of 100 percent of tax deferments for capital gains on the sale of principal residences, and the elimination of 100 percent of the exclusion of capital gains at death (Chapter 10). Sherraden explores several promising applications of the IDA, offers a detailed example of how they might work (Chapter 11), and considers how his policy contributes positively to the long-term economic goals of the United States.

Given the current lack of substantive welfare policy proposals, the comprehensive appraisal of the system that is provided by Sherraden's book is welcome. Certainly the current welfare system is no solution to the poverty problem; the average welfare family in the U.S. receives less than half of the poverty line income in benefits. The fact that those on welfare are not allowed to accumulate economic assets makes it even more difficult to overcome our poverty problem.

Sherraden's analysis raises several questions. Should the government dictate to the poor how they should allocate their assets when they have a pressing need to spend on necessities such as food, shelter, clothing, and health care? can educating poor individuals solve the poverty problem, given Braun's documentation of the lack of enough well-paying jobs in our declining economy? Is it desirable and politically feasible to fund a poverty program through proposals which increase taxes for the middle class?

However, in any review of an area as complex as poverty and welfare policy there are bound to be a few unanswered questions both of these books document the fact that economic inequality is caused by basic features of our economic and political systems, and they discuss what we ought to do about those systems. We hope that future authors will do the same, rather than continue to blame the victims of poverty for their plight.

Résumés

Vers une meilleure compréhension de la paranoïa:
Une explication sociale du phénomène

David May et Michael P. Kelly

Dans cet article, les auteurs proposent une explication essentiellement sociologique de la paranoïa à partir de l'étude détaillée du cas d'une femme célibataire, ancien professeur, qui pendant 30 ans se considérait la victime d'un groupe imprécis de conspirateurs ayant le pouvoir de contrôler ses pensé es et ses actes. En s'inspirant de l'étude approfondie de Lemert, parue en 1962, les auteurs postulent que la paranoïa se comprend mieux, non pas en tant que maladie au sens médical du terme, mais plutôt en tant qu'effort dé sespéré de la part de la victime pour se protéger des effets de l'image que se fait d'elle le public, une image en désaccord avec l'image de soi. L'ambition frustrée, les échecs répétés et l'isolement affectif servent d'explication à l'origine de la paranoïa.

Une compréhension alternative des caractéristiques cognitives, affectives et comportementales chez les individus élevés dans des familles d'alcooliques:
Une théorie clinique de l'individu

John E. Glass

Du point de vue historique, la sociologie médicale a évalué le comportement problématique de l'individu en tant que reflet des circonstances et des situa-

tions sociales immédiates. Les champs d'intervention des praticiens se limitaient à l'isolement des facteurs circonstanciels qui contribuaient à la détresse de l'individu. Cet article postule que le comportement problématique de l'individu a des origines sociales. Les stratégies d'intervention sont à rechercher non pas au niveau INTER-personnel, mais plutôt au niveau INTRA-personnel, c'est-à-dire, chez l'individu lui-même. L'argument est fondé sur une théorie bien établie de la sociologie traditionnelle. L'auteur a élaboré son point de vue à partir d'une étude d'individus élevés dans des familles d'alcooliques.

La crise actuelle de la sociologie

Phillip D. Robinette

Des variables empruntées aux études consacrées à l'analyse des problèmes qui, vers la cinquantaine, surgissent chez les Américains ont été utilisées dans cet article afin d'évaluer le développement de la pratique sociologique (appliquée et clinique) en tant que spécialisation complémentaire au sein de cette discipline. Pour permettre à la pratique de la sociologie de survivre, et éviter les pièges éventuels, les solutions préconisées dans cet article méritent d'être considérées.

L'intégration des théories psychodynamiques, cognitives et interpersonnelles: Une théorie de rôle comprenant des éléments biopsychosociaux

Tamara Ferguson, Jack Ferguson et Elliot D. Luby

Une théorie de rôle biopsychosociale a été utilisée dans cet article pour intégrer les ré sultats principaux de thérapies psychodynamiques, cognitives et interpersonnelles. Afin de fonctionner harmonieusement dans une société, l'individu doit maintenir en équilibre non seulement ses propres aspirations et performances, mais également les attentes d'autrui à son égard, ainsi que les performances d'autrui en ce qui constitue les 16 besoins biopsychosociaux fondamentaux, ou vecteurs de vie. Le stress résulte d'un déséquilibre entre les aspirations et les performances d'un individu. Une personne sujette au stress a deux options: elle peut modifier ses aspirations et ses performances, et les négotier avec autrui ou être guidee par des mécanismes de défense qui la poussent à agir automatiquement ce qui ne fait que d'aggraver sa sit-

uation. Dans cette étude, les malades, leurs conjoints et leurs parents ont été interviewés selon un modèle uniforme. Des résumés personnels permettent aux personnes interviewés d'identifier leurs problèmes tout en leur fournissant une structure, une méthodologie et un langage communs. Grâce à ce procédé, les interviewés sont en mesure de résoudre leurs différences d'opinion et de restructurer leurs rôles. C'est ainsi, donc, qu'un individu peut atteindre à la fois ses objectifs personnels aussi bien que ses objectifs interpersonnels.

Groupes formés pour l'apprentissage effectué en profondeur:
Ou comment allier l'apprentissage émotionnel à l'apprentissage intellectuel

Valerie Malhotra Bentz

Cet article examine certains groupes spécialisés dans l'apprentissage effectué en profondeur, ou "deep learning". Ces groupes sont à la recherche de vérités validées consensuellement (l'apprentissage intellectuel) d'une part, et de la compréhension des émotions (l'apprentissage émotionnel), d'autre part. Le processus du "deep learning" accroît le pouvoir de maturation des membres du groupe. Les groupes de "deep learning" doivent beaucoup aux théories avancées par Jürgen Habermas, Robert Langs et Virginia Satir. L' auteur fournit quelques exemples de "deep learning" à partir des transcriptions obtenues lors de deux séminaires de groupe (en l'occurence, ceux de Thomas Scheff et de Valerie Bentz). Le processus du "deep learning" est caracté risé par une catharsis d'identification et de libération des phénomènes qui, tout en menant à une meilleure appréciation des faits, sert également à élucider toutes questions nouvelles qui pourraient se poser.

Le syndrome de la mort subite du nouveau-né: la façon dont les mécanismes de soutien social agissent pour protéger les parents du stress

Diana Torrez

Cette étude examine les rapports entre les mécanismes de soutien social et les effets liés au syndrome de la mort subite du nouveau-né. L'auteur explore l'effet de la participation dans les groupes d'entre-aide pour personnes affligées et, en particulier, la manière dont ces groupes interviennent pour soulager la peine des personnes concernées. Les données sur lesquelles ces facteurs sont on été basés sur 31 interviews personnelles de parents ayant

subi la mort d'un nouveau-né. Ces données ont été analysées à l'aide d'un modèle "inhibiteur" de stress, à effet tampon. Ce modèle sert à démontrer l'effet exercé sur le stress par les groupes de soutien social.

Une comparaison de l'effet psychologique du "syndrome de la femme battue", du viol par le conjoint et du viol par un inconnu

Nancy Shields

Dans cet article, l'auteur compare l'effet psychologique que le "syndrome de la femme battue", le viol par le conjoint et le viol par un inconnu ont sur les victimes en question. Les femmes qui ont été battues ou violéés par leur conjoint sont comparées à celles qui ont été violées par un inconnu, en particulier en ce qui concerne leur comportement psychologique suite au viol. A cet effet, l'auteur se sert de l'inventaire sommaire de symptômes établi par Derogatis (BSI). Le BSI mesure toute une série de comportements, notamment: les troubles obsessionnels et compulsifs, la sensibilité interpersonnelle, la dépression, l'anxiété, l'hostilité, l'anxiété phobique, l'idéation paranoïde ainsi que les troubles relatifs à la psychose de l'individu. L'auteur compare également le comportement sexuel des victimes. Dans l'ensemble, les victimes du viol par le conjoint ont un score plus élevé àl'échelle du BSI que les victimes battues ou violées par un inconnu. En ce qui concerne l'idéation paranoïde et les troubles psychotiques, les victimes du viol par le conjoint ont un score nettement plus élevé que les victimes du viol commis par un inconnu. Pour la plupart des facteurs mesurés àl'echelle du BSI, le score des victimes du viol par le conjoint est aussi nettement plus élevé que celui des femmes battues. Les statistiques concernant les femmes battues étaient comparables à celles des victimes du viol par le conjoint. Les victimes du viol par le conjoint et celles qui avaient été battues indiquent des taux d'activité sexuelle semblables à ceux des victimes du viol par un inconnu. Leurs taux, cependant, sont nettement plus bas en ce qui concerne le plaisir sexuel. L'auteur discute ses résultats à partir d'une perspective sociologique sur l'effet relatif du viol par le conjoint ou par un inconnu et du "syndrome de la femme battue".

Le retour à une tradition bien fournie: Une perspective sociologique du lieu de travail et des changements industriels au niveau de l'économie mondiale

Marvin S. Finkelstein

La sociologie dispose d'une tradition riche et profonde dans le domaine de l'industrie, du travail et des organisations. Sa prééminence antérieure sur ce plan, cependant, reste enfouie sous de multiples couches de recherche et de pratiques que d'autres disciplines se sont appropriées. Ceci est particulièrement décevant si l'on considère l'absence notoire de participation de la part des sociologues aux changements importants survenus dans l'industrie, c'est-à-dire, en ce qui concerne une conception plus souple, moins figée du lieu de travail. Ce qui fait surtout défaut, selon l'auteur, c'est une structure théorique permettant de formuler une approche essentiellement sociologique décrivant le rôle du sociologue de façon claire et précise. Cet article voudrait encourager les sociologues à redécouvrir leur héritage. A cette fin, l'auteur situe la sociologie dans son contexte tout en examinant de près les dimensions théoriques, méthodologiques et pratiques de trois praticiens éminents. Les portraits de ces trois praticiens servent à mettre en évidence les caractéristiques saillants qui les différencient les uns des autres. L'auteur nous propose un plan schématique des rôles du sociologue et du praticien.

Analyse d'un programme communautaire d'intervention: la prévention de l'abus de drogues

Marguerite E. Bryan

La littérature qui se rapporte à la prévention de l'abus de drogues indique que le fait de grandir dans une famille adonnée à l'alcool et à d'autres drogues est étroitement lié au comportement problématique chez les enfants, par exemple, en ce qui concerne la délinquance, l'alcoolisme et les drogues. Le but de cette étude consiste à evaluer l'applicabilité ou l'efficacité de l'intervention chez les enfants noirs américains toxicomanes, en particulier en ce qui concerne leur succès scolaire. Une version modifiée du modèle de services d'assistance aux étudiants a été utilisée dans le contexte présent. L'étude examine plus précisement l'effet de la variable indépendante—le nombre de fois que l'étudiant a participé dans les programmes de conseil—sur les variables dépendantes qui nous intéressent ici, c'est-à-dire, la moyenne obtenue par l'élève à la fin de l'année scolaire ainsi que l'absentéisme, tels qu'ils sont relevés dans son bulletin scolaire de fin d'année. L'auteur note une amélioration dans la performance scolaire, en particulier parmi les Noirs américains de sexe masculin. Cette amélioration est due, d'une part, à la technique d'intervention qui a pour but de socialiser les enfants en les protégeant de l'alcool et des drogues, et, d'autre part, à la manière dont la famille aborde le problème de la dépendance.

L'identification de la violence dans les présentations de cas psychiatriques

Edward W. Gondolf et Joyce McWilliams

La recherche effectuée antérieurement sur le discours médical semble indiquer que les médecins ont tendance à minimiser les problèmes sociaux des malades pendant leurs conversations avec ces derniers. Dans le passé, le personnel psychiatrique négligeait souvent de rapporter et d'évaluer les discussions des patients où il était question de la violence dont ceux-ci avaient fait l'objet. Les auteurs abordent cette problématique importante en examinant les présentations de cas de 77 malades psychiatriques violents. A partir d'une analyse contextuelle de la violence mentionnée au cours de ces présentations de cas, les auteurs réussissent à dégager quatre catégories d'identification, à savoir: la violence en tant que partie intégrante du problème principal, la violence en tant que trouble psychiatrique, la violence sans rapport avec l'incident et la violence carrément passée sous silence. Dans presque les deux tiers de ces présentations de cas, la violence n'est pas identifiée comme faisant partie du problème principal. Ces résultats et ces exemples de cas établissent le bien-fondé de l'affirmation des auteurs selon laquelle les problèmes sociaux sont négligés, minimisés ou médicalisés dans le discours médical. Cette étude souligne, de plus, l'importance de la formulation de directives pour le personnel psychiatrique afin que celui-ci prenne davantage en considération tout incident de violence signalé par un malade.

Troisième partie d'une intervention transculturelle: quelques corrections et mise à jour du cas de la femme aux cheveux ensorcelés

Sophie Koslowski et Jonathan A. Freedman

Dans ce bref exposé, le troisième d'une série concernant Mme Koslowski, les auteurs explorent la façon dont cette dernière parvient au bout de onze ans à briser le sort qui avait été jetésur ses cheveux. Tout en corrigeant quelques erreurs antérieures et en présentant une analyse, cet exposé tente de faire le point sur cette affaire.

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