1-1-1991

Full Issue: Volume 9

CSR Editors

Follow this and additional works at: http://digitalcommons.wayne.edu/csr

CLINICAL SOCIOLOGY REVIEW
Volume 9, 1991

Editorial Board

Acknowledgments Every article submitted to the *Clinical Social Review* is read by at least one member of the editorial board or an associate or assistant editor, and at least two other reviewers. These reviewers are chosen because of the relevance of their knowledge for evaluating the manuscript.

A number of authors have commented on both the thoughtfulness and helpfulness of the reviewers' comments. This is a real tribute to those colleagues who have served so well in this capacity.

The *Clinical Sociology Review* acknowledges with thanks the following special reviewers:

CLINICAL SOCIOLOGY REVIEW
Volume 9, 1991

The *Clinical Sociology Review* is published annually by the Michigan State University Press, in association with the Sociological Practice Association, a professional organization of clinical and applied sociologists. Abstracts of all articles appear in *Sociological Abstracts* and selected abstracts appear in *Social Work Research and Abstracts*.

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. Manuscripts will be reviewed both for merit and for relevance to the special interests of the *Review*.

Manuscript submissions should follow the Sociological Practice Association style guidelines, including reference citation style, and should include an abstract. 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 editor: Susan Brown Eve, University of North Texas, Denton, TX 76203; (817) 565-2663. When possible, 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.

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

Subscription inquiries should be sent to the publisher: The Michigan State University Press, 25 Manly Miles Building, 1405 S. Harrison Road, East Lansing, MI 48823-5202.

Membership and other inquiries about the Sociological Practice Association should be sent directly to the executive officer/treasurer: Dr. Elizabeth Clark, Department of Social Work, New Scotland Avenue, Albany Medical Center, Albany, New York 12208.

CLINICAL SOCIOLOGY REVIEW
Volume 9, 1991

Contents

BOOK REVIEWS

Editor's Preface

Volume 9 has been a joint effort of the Editor and the Editor-Elect. While the present editor has had the final responsibility for this issue, to the extent possible articles were reviewed and decisions made jointly with the Editor Elect. Susan Eve assumes the Editorship beginning with Volume 10. She has assembled an exciting group of associate and assistant editors. She inherits a group of reviewers who are dedicated and compassionate. The names of special reviewers for this year's issue appear elsewhere in the introductory material. I thank them for what they have done as she will thank them for what they will do. The success that the Journal has had in stimulating a clinical literature in sociology is, in no small measure, the result of the dedication of these reviewers.

Susan Eve has assembled an outstanding editorial group to work with her: John Glass of Studio City, California, and David Watts of Southeastern Louisiana University will be Associate Editors. Assistant Editors include John Bruhn of the University Texas Medical Branch, Texas, and Louisa Howe of the Psychomotor Institute of Cambridge, Massachusetts. Jan Fritz, California State University, San Bernardino, will continue to edit the Historical Section. Sara Brabant, University of Southwestern Louisiana, will edit Teaching Notes, and H. Hugh Floyd, Jr. of Metaire, Louisiana, will edit Practice Notes. Elizabeth Clark continues as Consulting Editor. Harry Cohen of Iowa State University became Book Review editor for this issue and will continue in that role. Peggy Higgins becomes editorial assistant. I am sure that they will provide an exciting journal.

Volume 9 of the *Clinical Sociology Review* maintains the same format as in previous years. Because of the nature of the submissions to the journal, this year there is a greater emphasis on practice and a lessened emphasis on theory than in previous years. The focus on teaching appears in the Historical Section, rather than in a section of its own.

History of Clinical Sociology. Jan Fritz begins with a review of some of the early courses in clinical sociology, which intertwined with sociologists' involvement in child guidance clinics. "The Emergence of American Clinical Sociology: The First Courses" describes what is known about some of these courses.

Alfred McClung Lee and Elizabeth Briant Lee are major figures in American sociology. Founders of the Society for the Study of Social Problems and of the Humanist Sociology Association, and major inspirations for the Sociological Practice Association, their careers span more than half a century of American sociology. Their "Lifetimes in Humanist Sociology," presented originally at the 1990 Sociological Practice Association meeting, is an autobiographical reminiscence. This is followed by a selected bibliography of their work prepared by Jan Fritz.

Theory of Clinical Sociology. Three articles appear in this section. In "Socio-Legal Definitions of the Family" Jean Thoreson uses legal cases to show how judges' interpretations of legislation can define the nature of family. Melvyn Fein, "Personality Disorders or Role Negotiation Problems," discusses ways in which disorders defined by the DSM-III are in reality problems of role negotiation. Without renegotiation of roles, persons defined as psychiatrically disabled will not be able to construct satisfying lives for themselves. In "Clinical Sociology and Religion" C. Margaret Hall shows how a sociological understanding of the meaning of religion can enable the socio-therapist to help clients whose religious beliefs affect their daily life.

Practice of Sociology. The practice of sociology is not limited to the United States. The sessions sponsored by the Research Committee on Sociotechnics-Sociological Practice at the International Sociological Association congress in Spain in the summer of 1990 included presentations by sociologists from many other countries. The paper by Hendrik W. van der Merwe and Andries Odendaal was one of these. In South Africa, the Centre for Intergroup Studies at the University of Cape Town has long been involved in constructing a dialogue between the White and the Black populations of South Africa. The means by which this is accomplished is reported in "Constructive Conflict Intervention in South Africa: Some Lessons."

Three health related papers follow. Thomas W. Plaut, Suzanne Landis, and June Trevor show how "Combining Sociology and Epidemiology" resulted in an innovative community-based health program in the rural South. Linda Weber presents the sociologist's role in the development of health maintenance programs for local government. Jeffrey Sobal's "Obesity and Nutritional Sociology: A Model for Coping with the Stigma of Obesity" looks at the problem of

obesity from a sociological standpoint and suggests ways in which sociological intervention might be helpful to those defined by society as "fat."

This section concludes with two papers that focus on social problems. **Mary Cay Sengstock, Melanie Hwalek** and **Carolyn Stahl** examine the effectiveness of a variety of ways of offering services to older citizens who are at risk for elder abuse. "Developing New Models of Service Delivery to Aged Abuse Victims: Does It Matter?" suggests that state agencies do not effectively differentiate service delivery models. A therapeutic wilderness program aimed at reducing delinquent behavior is the setting for "Explaining Delinquent Behavior among Adolescent Girls: Internal Social Control and Differential Association" by **Linda Rouse** and **Raymond Eve** . This study confirms ways that internal social controls can act as barriers to delinquent behaviors while differential association may support such behaviors among these girls.

Book Reviews. Sociology has long studied death and loss, but only recently have sociologists begun to use their skills to help with the processes involved. **Russell Dynes** suggests that *Clinical Sociological Perspectives on Illness and Loss: The Linkage of Theory and Practice*, edited by Elizabeth J. Clark, Jan M. Fritz, and Patricia Rieker, contains material in this area that will be useful both for theory and for instruction.

Interactional problems may stem from interpersonal difficulties, from problematic definitions of the situation, or from role problems. According to **Beverley Cuthbertson-Johnson,** Nathan Hurvitz and Roger A. Straus present the basis for a cognitive approach to interpersonal difficulties in their *Marriage and Family Therapy, A Sociocognitive Approach.* The reviewer would like them to pay more attention to emotions as well. According to **Gladys Rothbert,** Paul Watzlawick's *Munchhausen's Pigtail or Psychotherapy and "Reality"* emphasizes how clients define the situation and then act on those definitions. Clients may need to change the beliefs on which they act, selecting in advance the definitions of the situation which will result in the consequences they desire. Role change and resocialization is also the focus of *Role Change: A Resocialization Perspective* by Melvyn Fein. **Novella Perrin** suggests that the ideas in this book should have a major impact on the practice of therapy. But not all therapy needs the help of a therapist. According to **Judyth L. Scott,** Roger A. Straus' *Creative Self Hypnosis: New Wide-Awake, Non-trance Techniques to Empower Your Life, Work and Relationships* presents a number of useful self-help techniques.

C. Allen Haney reviews two books on AIDS. *AIDS and the Allied Health Professions,* by Joyce W. Hopp and Elizabeth A. Rogers, is a useful summary for workers in the allied health professions, although it slights the psychosocial aspects of AIDS. *The Psychosocial Aspects of AIDS: An Annotated Bibliography,*

edited by Paula L. Levine, John G. Bruhn, and Norma H. Turner, is extremely detailed, and should be particularly useful for researchers in the field.

Guillermo J. Grenier spent time looking at quality circles at Ethicon-Albuquerque, and found they were used to increase management's power at the cost of the workers. **Anthony J. Riech** finds this an important book, particularly for those involved in labor management relations.

About the Authors

Raymond A. Eve, "Explaining Delinquent Behavior Among Adolescent Girls: Internal Social Control and Differential Association," is an associate professor in the Department of Sociology and Anthropology at the University of Texas at Arlington. His teaching interests include crime and delinquency, socialization and social control, deviant behavior, collective behavior and social movements, and computer applications in the social sciences. He has been a licensed professional counselor in Texas and has served by invitation on the Research Advisory Board of the Federal Bureau of Prisons. He is the author of numerous articles on the causes and treatment of delinquency.

Melvyn L. Fein, "Personality Disorder or Role Negotiation Problems," is a certified clinical sociologist in private practice in Rochester, New York. He holds a doctorate in sociology from the City University of New York, and has had almost twenty years of experience helping individuals solve their personal, relationship, and vocational problems. He has recently published *Role Change: A Resocialization Perspective* (Praeger), and is completing another book to be called *Analyzing Psychotherapy: A Social Role Interpretation*. He also teaches as an adjunct at the State University of New York College at Brockport. Among his current research interests are the medical model of personal distress and the social negotiation of moral rules.

Jan Fritz, "The Emergence of American Clinical Sociology: The First Courses," is a faculty member in the Department of Sociology at California State University, San Bernardino. She is also a director of four tobacco control projects, coordinator of the California chapter of the Sociological Practice Association, and President of the International Sociological Association Working Group in Clinical Sociology. She is co-editor of *Clinical Sociological Perspectives on Illness and Loss,* and of *Health Sociology,* the 1991 volume of *Sociological Practice.*

11

C. Margaret Hall, "Clinical Sociology and Religion," is a professor of sociology at Georgetown University, Washington, D.C. She has a private practice in clinical sociology, with specialization in family, gender and value concerns. Her clinical research has been published in interdisciplinary and sociology journals, and her work on theory construction in clinical sociology is the basis of her 1990 book, *Women and Identity: Value Choices in a Changing World.*

Melanie Hwalek, "Developing New Models of Service Delivery to Aged Abuse Victims: Does It Matter?," is President of SPEC Associates of Detroit, Michigan. She holds a Ph.D. in psychology from Wayne State University, and is an adjunct faculty member at Michigan State University and Wayne State University.

Suzanne Landis, "Combining Sociology and Epidemiology," is the director of the Community Oriented Primary Care Project. She is a diplomate of the American Board of Internal Medicine and the American Board of Preventive Medicine. She balances a medical practice with teaching in the Mountain Area Health Education Center Family Practice Residency Program in Asheville, North Carolina, and is also a clinical associate professor in the Department of Medicine of the University of North Carolina at Chapel Hill. Dr. Landis graduated from the University of Pennsylvania Medical School in 1978 and also holds a master's degree in Public Health and Epidemiology.

Elizabeth Briant Lee, "Lifetimes in Humanist Sociology," is a visiting scholar at Drew University. She is a co-founder of the Sociological Practice Association and a co-founder and past vice president of the Society for the Study of Social Problems. She was a co-founder and the second president of the Association for Humanist Sociology and is the author or co-author of numerous articles and books. She has received career awards from the Sociological Practice Association, the Eastern Sociological Association, and the American Sociological Association.

Alfred McClung Lee, "Lifetimes in Humanist Sociology," is a visiting scholar at Drew University and a professor emeritus of sociology and anthropology at Brooklyn College and the Graduate Center of City University of New York. He is a co-founder of the Sociological Practice Association, a co-founder and past president of the Society for the Study of Social Problems, and a co-founder and past president of the Association for Humanist Sociology. He also was a past president of the American Sociological Association and, from 1940 to 1942, the executive director of the Institute for Propaganda Analysis. He is the author of many books and articles, including *Sociology for People: Toward a Caring Profession.* He has received many career awards from the Sociological Practice Association and the American Sociological Association among others.

Andries Odendaal, "Constructive Conflict Intervention in South Africa: Some Lessons," is senior lecturer and head of the Department in Missiology at the University of the North, Qwa-Qwa branch. He was a visiting fellow at the Center for Intergroup Studies in Cape Town, South Africa, in 1990. He has a number of Afrikaans publications to his credit.

Thomas Plaut, "Combining Sociology and Epidemiology," came to Madison County in 1977 as a professor of sociology at Mars Hill College and a staff member of its Southern Appalachian Center. He became involved in the COPC project in the grant writing stage and, when funding was awarded, was asked to coordinate community assessment. He had previously helped organize hospice, victim assistance and housing programs in the county. He has published articles on the nature of community and social change in Appalachia and on interactional problems between medical and social services providers and rural clients. He received his Ph.D. from the Union Institute and an A.B. from Harvard.

Linda P. Rouse, "Explaining Delinquent Behavior Among Adolescent Girls: Internal Social Control and Differential Association," is an associate professor in the Department of Sociology and Anthropology at the University of Texas at Arlington, where she teaches courses in social psychology, family, evaluation research and statistics. She has written articles on social power, racial/ethnic stereotyping, spouse abuse and courtship violence. She also serves as an evaluation research consultant for social service programs.

Mary Cay Sengstock, "Developing New Models of Service Delivery to Aged Abuse Victims: Does It Matter?," is a certified clinical sociologist and professor of sociology at Wayne State University. She holds a Ph.D. from Washington University in St. Louis, Missouri.

Jeffery Sobal, "Obesity and Nutritional Sociology: A Model for Coping With the Stigma of Obesity," is an associate professor in the Division of Nutritional Sciences at Cornell University. He was a doctoral and postdoctoral student in sociology from the University of Pennsylvania and studied nutritional epidemiology at the Johns Hopkins University School of Hygiene and Public Health. He has been developing the area of nutritional sociology for over ten years and currently is investigating and practicing in his work on social patterns of obesity, vitamin/mineral supplement use, and nutritional ethics.

Carolyn Stahl, "Developing New Models of Service Delivery to Aged Abuse Victims: Does It Matter?," is bureau chief of the Planning and Program Development Bureau of the state of Illinois Department on Aging.

Jean H. Thoresen, "Socio-Legal Definitions of the Family," is professor of sociology and applied social relations at Eastern Connecticut State University in Willimantic. She received her undergraduate degree in sociology and anthropology from Mt. Holyoke College and her M.A. in sociology from the University of Connecticut. She received her J.D. from Western New England College School of Law, where she was a member of the *Law Review.* Her major research interests are in qualitative methods and deviant identity formation, and the role of law in constructing social realities.

June Trevor, "Combining Sociology and Epidemiology," has been project coordinator for Community Oriented Primary Care since September 1989. Prior to that she spent seven years organizing and directing community-based Adult Developmental Activity Programs (ADAP) in Madison County. She previously conducted surveys in the areas of health, housing and education for the Research Triangle Institute (RTI), Raleigh, North Carolina. She began her career as a Vista Volunteer community organizer.

Hendrik W. van Der Merwe, "Constructive Conflict Intervention in South Africa: Some Lessons," is director of the Centre for Intergroup Studies in Cape Town, South Africa. He is the author of *Pursuing Justice and Peace in South Africa* (Routledge, 1989), "White South African Elites" (1974) and "Legal Ideology and Politics in South Africa" (1986). He is founding president of the South African Association for Conflict Intervention, convener of the Conflict and Peace working group of the Association for Sociology in South Africa, a member of the national Council of the South African Institute of Race Relations, a member of the International Council of the Conflict Resolution Center, Inc., and of several other conflict resolution groups. He has been involved in several community action groups. In 1984 he initiated dialogue between South Africans and the African National Congress in exile.

Linda R. Weber, "The Sociological Practitioner in Organizational Health Promotion Programming," is an assistant professor of sociology at Glassboro State College in New Jersey. She is currently involved in the investigation of health identity and its relationship to participation in health-promoting behaviors. In addition, she is working with the O'Hara Center for Youth Development, one research component of the Boys and Girls Clubs of America, in the investigation of the "at-risk" status of youths.

The Emergence of American Clinical Sociology: The First Courses

Jan M. Fritz
California State University, San Bernardino

ABSTRACT

This article describes the first clinical sociology courses at the University of Chicago, Tulane University, New York University and Antioch College as well as the proposal for a clinical sociology department at Yale University. The author discusses why the earliest clinical sociology courses didn't become institutionalized in the late 1930s and early 1940s.

Information is provided here about the first courses in clinical sociology, one of the areas of sociological practice. Clinical sociology refers to humanistic analysis and intervention. Clinical analysis is the critical assessment of beliefs, policies and/or practices with an eye toward improving the situation. Intervention, the creation of new systems as well as the change of existing systems, is based on continuing analysis (Fritz, 1991b).

Clinical sociologists are multidisciplinary in approach. They engage in planned social change efforts by focusing on one system level (e.g., interpersonal, community, international) but integrate levels of focus in their work and do so from a sociological frame of reference (Fritz, 1989a).

Information about the work of the early clinical sociologists (e.g., Fritz, 1982, 1985a, 1987a, 1988, 1990b, 1990c, 1991a; Fritz and Clark, 1989; Glass, 1979; Hunter, 1988; Lee, 1979, 1982) has contributed to a more accurate history of the field of sociology and, in the last ten years, to a resurgence of interest in sociological practice. Information about the early clinical sociology courses

15

particularly will be useful to those establishing or developing programs in clinical sociology or sociological practice.

While it had been known that some of the early American sociologists had interests that could be characterized as "clinical" (e.g., Wirth, 1931; Alinsky, 1934), the assumption had been that even those academics who were clinically oriented had not actually taught courses in clinical sociology. We now know that is not the case. A number of courses had clinical components, but there also were courses actually titled "clinical sociology."

The earliest known proposal wasn't just for a course in clinical sociology but for a whole department (Fritz, 1989b; Gordon, 1989). The proposal was put forward by Milton C. Winternitz (1885–1959), a physician who was dean of the Yale School of Medicine from 1920 through 1935.[1] At least as early as 1929, Winternitz (1929, 1930a) began to develop plans to establish a department of clinical sociology within the medical school. He wanted each medical student to have a chance to analyze cases based on a medical specialty as well as a specialty in clinical sociology.

Winternitz vigorously sought funding from the Rosenwald Fund for his proposed program but, in the end, he was unable to carry out his plans. He (Winternitz, 1931a, 1931c) did note, however, the success of a course in the medical school's section on public health that was "modeled directly after the outlined plan for clinical sociology."

The first known courses called "clinical sociology" were taught at the University of Chicago by Ernest W. Burgess (1886–1966). Burgess, a graduate of the university who joined the faculty in 1919, is considered to be one of the second generation of sociologists who taught there. He was a central figure in the department until his retirement in 1951. During his career Burgess was president of the American Sociological Association, the Sociological Research Association, the National Conference on Family Relations, and the Gerontology Society.

Burgess first taught the clinical sociology course in 1928 and then offered it twice in 1929. During these years the course was considered to be "special" and did not appear in the course catalog. As a regular course, clinical sociology was offered a total of five times by Burgess from 1931 through 1933. The course remained in the catalog for the next several years, but was not taught after 1933.[2]

In 1929 Burgess wrote that "the time has now been reached when it will be profitable for biology, psychology, psychiatry and sociology to collaborate in the setting up of laboratories for personality study . . . ." This suggested that Burgess focused his clinical sociology course on issues of personality and criminal behavior.

The university catalogs did not include a description of that course but it always was listed only under the social pathology grouping. All courses in this section dealt with topics such as criminality, punishment, criminal law, organized crime and personal disorganization.

Because information about the course content was unavailable, some students who had been enrolled in the clinical sociology courses were contacted.[3] One of them, Joseph Symons,[4] was a graduate student at the University of Chicago from 1932 through 1936. In the fall of 1933 he was enrolled in Sociology 473 (clinical sociology) with E. W. Burgess as the instructor.

According to Symons' (1933) class notes, Burgess said that clinical sociology "denotes an interest in pathological cases" and focuses on "social interaction and cultural conditioning." The main concepts that were used in the course were identified as "ecological, social interaction, cultural conditioning, fundamental wishes, personality types and social types." During the course of the term, students were expected to use provided forms to analyze personalities and to conduct a case study.

The course was taught one night a week and each two-hour session began with a "discussion of certain written materials." The required reading included Edwin Bjorkman's *Gates of Life* (1923) and *The Soul of a Child* (1922), as well as Clifford Shaw's *The Natural History of a Delinquent Career* (1931) and *The Jack-Roller* (1930), "a delinquent boy's own story." Also on the reading list were Jack Black's (1926) *You Can't Win*, an account of Black's life as a professional thief, and Jane Hillyer's (1926) *Reluctantly Told,* the fascinating story of the author's mental breakdown.

Symons' notes indicate that in 1933 Burgess stressed the importance of sociologists in child guidance work. Symons had written "there are three types of children's clinics in the U.S." and these clinics are distinguished by leadership: "psychiatrists at head; psychologists at head; sociologists at head."

When the clinical sociology course was first offered, several students were placed in child guidance clinics. One of these students, Clarence E. Glick (1989), took the clinical sociology course each time it was available in the 1920s. Burgess arranged for Glick to be the staff sociologist at the Lower North Side Child Guidance Clinic[5] and another class member, Leonard Cottrell, was the clinical sociologist at the South Side Child Guidance Clinic.[6]

Two other universities offered clinical courses in the 1930s—Tulane University in Louisiana and New York University. Louis Wirth, a full-time faculty member at Tulane and director of the New Orleans Child Guidance Clinic,[7] was scheduled to teach "clinical sociology" in the spring of 1930.

Wirth was unable to teach the course because he accepted a one-year Social Science Research Council Fellowship to work in Europe from February 1930

to January 1931. The clinical sociology course was taught in his absence, but university files do not identify the professor who took Wirth's place.

According to the *Tulane University Bulletins* (1928–29), the course was a "clinical demonstration of behavior problems and practice in social therapy through staff conferences and field work in a child guidance center." The course was entered in the school catalog as part of the sociology, social work, and graduate school listings.

When Wirth returned to the United States in 1931, he joined the faculty at the University of Chicago. In the spring of 1932, he taught a "minor" course in clinical sociology for the University of Chicago. This course was listed in a special section of the catalog, and was recorded in the *Instructors' Reports* (University of Chicago, 1932). The course focussed on "personality problems and conduct disorders" and discussed "the place of sociologists in child guidance clinics"[8] (University of Chicago, University College, 1931-32:16).

By 1932 it appears that Wirth was no longer involved with child guidance clinics. Anna Hyman (1932), a staff member of the New Orleans Child Guidance Clinic, wrote Wirth to tell him that the New Orleans Clinic was closing because of a lack of funds. She asked Wirth if he knew of any job possibilities. In his letter of June 17, Wirth indicated he had "been somewhat out of touch with clinical work recently."

Another institution that offered clinical sociology courses in the early 1930s was New York University. Harvey Warren Zorbaugh (1896–1965) was a faculty member there in the School of Education. The School provided undergraduate and graduate preparation for visiting teachers,[9] clinicians,[10] and social workers.[11] The major focus of the program was the "*solution* of educational and other social programs" (New York University, Department of Educational Sociology and Anthropology, n.d.:5).

In 1930 Zorbaugh, along with Agnes Conklin, was responsible for the "Seminar in Clinical Practice." The seminar was described in the following way in the school bulletin (New York University, School of Education, 1930–31:143):

> The course will be limited to students training as specialists in the adjustment of behavior problems in the schools. It is assumed that candidates for the doctorate will register for the course only when their thesis projects are pertinent to the field of behavior maladjustment. All registrants will be required to participate in the handling of cases in the clinic for the social adjustment of the gifted. Completion of the course

is intended to qualify students as counselors or advisers dealing with behavioral difficulties in the school situation.

From 1931 through 1933 the clinical practice course was called "Seminar in Clinical Sociology" (New York University, School of Education, 1931–32:90, 156; 1932–33:151). The course (320.3–4) was one of the highest numbered courses in educational sociology and was offered both terms of each year. The university catalog stated only the following about the course: "Open to graduate students writing theses or engaged in research projects in the field of educational guidance and social work."[12]

Zorbaugh (1929), author of *The Gold Coast and the Slum: A Sociological Study of Chicago's Near North Side*, had been involved with clinics at least since 1924. That was the year Zorbaugh and Clifford Shaw organized two " 'sociological' clinics" in Chicago—the Lower North and South Side Child Guidance Clinics (Zorbaugh, 1939:348). Zorbaugh has been credited with being associate director of the Lower North Child Guidance Clinic in 1925 (New York University, School of Education, 1940–41:32).

In 1928 Zorbaugh was a founder of the Clinic for the Social Adjustment of the Gifted at New York University (New York University, Department of Educational Sociology and Anthropology, n.d.:2). He was director of this clinic at its inception and was actively involved in its work for over fifteen years.[13] The clinic allowed for "supervised experience in visiting teaching and in the clinical diagnosis and treatment of problem children" (New York University, School of Education, 1929–30:75). In 1941, thirteen years after the clinic had first opened its doors, the clinic was described in the following way (New York University, School of Education: 1941–42:53):

> . . .a child-guidance clinic for intellectually gifted and talented children of preadolescent ages. Studies are made of children's abilities, personalities, and achievements. Consultation on family relationships, educational guidance, and mental hygiene are among the services available.

During the 1953–54 academic year, Alvin W. Gouldner (1920–1980) was teaching in the Department of Sociology and Anthropology at Antioch College, a progressive school in Ohio. Before joining the faculty, Gouldner had been a university teacher for four years and then had worked for one year as a consultant to Standard Oil of New Jersey.

Gouldner offered "Foundations of Clinical Sociology" at Antioch. The course was taught at the highest undergraduate level and enrolled students

were expected to have successfully completed the department's course in social pathology. The course is described as follows in the *Antioch College Bulletin* (1953:123):

> A sociological counterpart to clinical psychology, with the group as the unit of diagnosis and therapy. Emphasis on developing skills useful in the diagnosis and therapy of group tensions. Principles of functional analysis, group dynamics, and organizational and small group analysis examined and applied to case histories. Representative research in the area assessed.

The earliest courses titled "clinical sociology"—at the University of Chicago, Tulane, New York University, and Antioch—appear to have focused on case analysis at the individual or small group level. Contemporary courses in clinical sociology, described in *Clinical Sociology Courses* (Clark and Fritz, 1984) and *The Clinical Sociology Resource Book* (Fritz and Clark, 1986), generally include case analysis at both micro and macro levels but there frequently is an emphasis on the individual and small group levels. It is helpful in a number of ways to know that the contemporary courses are part of a sixty-year tradition. But reading this history leaves one with an interesting question: Why didn't the courses called "clinical sociology" become institutionalized in the late 1930s and 1940s?

Zorbaugh's interests in clinical work certainly continued for many years after the course title was changed. His interdisciplinary focus may have led him to stop referring to the course as "clinical sociology."[14] Zorbaugh believed that the behavioral sciences were drawing closer together and that in the future sociologists would be able to participate, without opposition, in the work of clinics (Zorbaugh, 1939:351).

Burgess' clinical sociology courses drew upon the experiences of those working in the child development clinics. In the mid–1930s Burgess moved away from work in the clinics, so it is not particularly surprising to find that he didn't offer the courses again.

But why did Burgess and Wirth become less interested in child development clinics? One reason may have been that the Commonwealth Fund, a major funding source for the clinics, thought the clinics should be run by psychiatrists.[15] Wirth certainly had run into this problem while working in New Orleans (Horn, 1989:90–91). This may have been a case of sociologists not wanting to fight a turf battle.

There may be a host of other reasons that help explain why Burgess and Wirth moved away from work in the clinics. These could include the direction

of the sociology program at the University of Chicago or the draw of other community, academic, or research interests. Other possible reasons:

- Burgess never may have had a central interest in the child development clinics. It may have been that, for a period of time, they simply were convenient community laboratories.
- Perhaps there no longer was local funding for sociologists to work in the clinics.
- Perhaps fewer students were interested in being involved in the clinics.
- Perhaps the clinics were no longer in existence or no longer required the services of the sociologists.

A combination of reasons probably explains Wirth's and Burgess' movement away from clinics. It is clear, however, that Zorbaugh, Wirth, and Burgess did not put a professional network in place that would support the continuance and growth of sociological work in clinics. Without a network, their individual efforts were not continued or easily remembered.

NOTES

1. A discussion of Dean Winternitz's interest in clinical sociology as well as reprinted articles and letters by Winternitz are found in the 1989 issue of the *Clinical Sociology Review* (Fritz, 1989b; Gordon, 1989; Winternitz, 1930a, 1930b).

2. Clarence Glick (1989) studied at the University of Chicago from 1927 to 1929, 1932 to 1934 and again during the 1937–38 academic year. When asked why Burgess might not have continued teaching clinical sociology, he replied:

> Burgess became absorbed [along with Cottrell] in marital prediction. . . the success and failure of marriage. When Ogburn came to the department in 1927 a split [developed] between the statisticians and those doing case studies.
>
> Cottrell had been working with Burgess on case studies but Ogburn influenced Cottrell and he. . . [began using] questionnaires. Burgess started to go along [and] moved away from case studies.

3. Enrollment information was found in the *Instructors' Reports* (University of Chicago, Office of the Recorder, 1928–1938).

4. I am indebted to Dr. Symons for sharing his course materials. I appreciate his taking the time to help with this project.

5. Glick's (1989) role at the Lower North Side Child Guidance Center was as part of the diagnostic team for the case load of "problem" boys though Glick says the psychiatrist in charge of the clinic barely tolerated the young sociologist who had been made a colleague. Glick interviewed each boy about his "social world" and interviewed relevant community members about each boy's situation. Glick was a team member for analysis and diagnosis and, at times, also was an intervener. Glick says the goal of the center was to "help get the boy on the right track."

Glick says he remembers little of the course which he thinks was a tutorial. He took the paid job in the center because Burgess offered it "as a way to be able to stay in school." After he left the center Glick said he didn't think about continuing that kind of work because "it wasn't my specialty."

6. Leonard S. Cottrell (1899–1985) was for two years a "Clinical Sociologist for the Institute of Juvenile Research" and acted as such with the South Side Guidance Clinic (Cornell University Archives, n.d.). Cottrell (1929:1) wrote that the duties included:

> intensive treatment work, such as attempting treatment of the home situation, placement of the child in foster home, vocational adjustment, adjustment in school, cooperation with settlement in recreational adjustment. . . .

7. Wirth's 1931 article, "Clinical Sociology," discusses the importance of sociological contributions to the work of child development clinics. According to a newspaper article (September 18, 1929) in the *Tulane Scraps*, scrapbooks that are part of the Tulane University Library Archives, Louis Wirth had been director of the local clinic. Wirth never mentions in his 1931 article that he had been a clinic director.

8. Alexanderene Liston Fischer (1988), a 90-year-old retired teacher from Michigan, was one of the 18 students enrolled in the course. She remembered taking part in the class but nothing of the content. She also said she "would have loved to have been a sociologist but at that time they weren't getting much pay."

9. The visiting teacher, "a specialist in the study of home backgrounds," was described as follows (New York University, School of Education, 1929–30:75–76):

> Her function is to play between (home and school), establishing the rapport necessary for the adjustment of the problems of school children. Her specialized knowledge must include interviewing, taking and interpreting family histories, using community social agencies wherever necessary, and contributing to the understanding of the families visited. In addition to this emphasis in her training, she must have thorough orientation in types of behavior, in the salient characteristics of exceptional children, in tests and measurements, and in social research.

10. The clinician, "a specialist in the analysis and readjustment of behavior disorders, was described in the following way (New York University, School of Education, 1929–30:76):

> In addition to the training already outlined for the visiting teacher, he must acquire a considerable experience in clinical practice—administering tests, interviewing, evaluating the array of data with reference to a specific case, conducting staff conferences, prescribing treatment, and supervising the rehabilitation of the individual problem in question. His knowledge of behavior aberrations must be supplemented by specialized knowledge in such relevant fields as psychotherapy, neurology, endocrinology, social adjustment, the psychology of school subjects, and statistics.

11. This 1930 list—visiting teachers, social workers, and clinicians—was changed in 1931 (New York University, School of Education, 1931–32:98) to read as follows: "visiting teachers, educational counselors, social workers, and persons engaged in the administration of guidance in schools." Zorbaugh was director of the curriculum in this area as well as the undergraduate curriculum for "workers, administrators in boys' clubs, social settlements, and other educational agencies for children."

12. I am indebted to Dr. Elsie Hug (1990), the 86-year-old author of a 1965 book on the history of the New York University School of Education, for providing some detail about Zorbaugh's work and colleagues at New York University. Any errors in fact or analysis, however, should be attributed to the author rather than to Dr. Hug.

Hug first met Zorbaugh in the 1920s when she was working as a typist for the department and later she was a student in his educational sociology course. Hug said she argued with Zorbaugh that his clinic was not really a clinic as it didn't deal with the individual. Zorbaugh, an avid bridge player, didn't directly respond to Hug's criticisms. Hug said Zorbaugh chose, instead, to tell her that she was a lousy bridge player and sometimes a lousy educator.

13. During the following years the course was offered under the title "Seminar in Guidance and Special Education" (New York University, School of Education, 1933–34:165)

14. A departmental history (New York University, Department of Educational Sociology and Anthropology, n.d.:4) indicates that Zorbaugh became chair of the department in 1945 and was, at that time, devoting "a great deal of energy. . . to the Gifted Child Clinic."

15. According to a departmental history (New York University, Department of Educational Sociology and Anthropology, n.d.:5,2), Zorbaugh "did not focus directly on the use of sociological perspectives in analyzing or solving educational problems." However, Zorbaugh's involvement with the gifted child clinic is discussed at another point in the paper. There it states "Zorbaugh felt that the gifted child's handling of himself in society was a sociological and not a psychological problem."

16. According to Margo Horn (1989:ix, 186):

> In the years from 1922 to 1945, the child guidance movement in the United States was funded and operated through programs of the Commonwealth Fund. . . . So the early years of institution-building witnessed a defensive protection of the idea of a new psychiatric model of treatment, even before it was established, against encroachments by practitioners of the so-called old style of psychiatry or by promoters of the sociological approach.

SELECTED REFERENCES

Alinsky, Saul
>   1934   A sociological technique in clinical criminology. *Proceedings of the Sixty-Fourth Annual Congress of the American Prison Association* (September 17–21): 167–78.

Antioch College
>   1953   *Bulletin.*

Bjorkman, Edwin August
>   1922   *The Soul of a Child.* New York: A. A. Knopf.
>   1923   *Gates of Life.* New York: A. A. Knopf.

Black, Jack
>   1926   *You Can't Win.* New York: Burt.

Burgess, Ernest W.
>   1925a   Letter to Harvey Zorbaugh. March 10. Ernest Burgess Collection, University of Chicago, Regenstein Library. Box 26, Folder 9.
>   1925b   Letter to Harvey Zorbaugh. March 24. Ernest Burgess Collection, University of Chicago, Regenstein Library. Box 26, Folder 9.

1929   *Personality and the Social Group*. Chicago: University of Chicago Press. Reprinted in 1969 by Books for Libraries Press: Freeport, New York.

1946   Letter to Harvey Zorbaugh. November 12. Ernest Burgess Collection, University of Chicago, Regenstein Library. Box 26, Folder 9.

Clark, Elizabeth, and Jan Fritz

1986   The clinical approach to successful program development. *Clinical Sociology Review* 4:173–81.

Clark, Elizabeth, and Jan Fritz (eds.)

1984   *Clinical Sociology Courses: Syllabi, Exercises and Annotated Bibliography*. Washington, D.C.: American Sociological Association Teaching Resources Center.

Cornell University Archives

n.d.   Leonard S. Cottrell, Biographical statement for promotion. Leonard S. Cottrell file, 1935–1985. Cornell University, Department of Manuscripts and Archives.

Cottrell, Leonard S.

1929   Report of the Sociologist of the South Side Child Guidance Center for the period from January 1, 1928 to June 1, 1929. Ernest Burgess Papers. Box 13, Folder 4. Department of Special Collections, The Regenstein Library, University of Chicago.

Fischer, Alexanderene Liston

1988   Telephone interview. November 1.

Fritz, Jan

1985a   Symposium on the history of clinical sociology: Howerth, Small and sociological practice. *Clinical Sociology Review*, 3:13–15.

1985b   *The Clinical Sociology Handbook*. New York: Garland.

1986   History of clinical sociology: The initial contributions of Edward McDonagh and Marie Kargman. *Clinical Sociology Review*, 4:11–13.

1987a   The history of clinical sociology: The Whyte line. *Clinical Sociology Review*, 5:13–16.

1987b   W.E.B. Du Bois, scholar-practitioner. *The Practicing Sociologist* (Fall/Winter).

1988   The history of clinical sociology: Charles Gomillion, Educator-Community Activist. *Clinical Sociology Review*, 6:13–21.

1989a   The history of clinical sociology. *Sociological Practice*, 7:72–95.

1989b   Dean Winternitz, clinical sociology and the Julius Rosenwald Fund. *Clinical Sociology Review*, 7:17–27.

1990a   The uses of sociology in clinical settings. Pp. 10–22 in Elizabeth Clark, Jan Fritz, Patricia Rieker (eds.). *Clinical Sociological Perspectives on Illness and Loss: The Linkage of Theory and Practice*. Philadelphia: The Charles Press.

1990b   Notes from the history of American sociology: Frank Blackmar's last years at the University of Kansas. *Mid-American Review of Sociology*. 14/1 (Winter):13–26.

1990c   In pursuit of justice: W.E.B. Du Bois. *Clinical Sociology Review* 8:15–26.

1991a   The emergence of American clinical sociology. Pp. 17–30 in Howard Rebach and John Bruhn (eds.). *The Handbook of Clinical Sociology*. New York: Plenum.

1991b   The contribution of clinical sociology in health care settings. *Sociological Practice: Health Sociology* 9:15–29.

Fritz, Jan (ed.)

1982   *The Clinical Sociology Review*. 1. Clinical Sociology Association.

Fritz, Jan, and Elizabeth Clark (eds.)

1986   *The Clinical Sociology Resource Book*. Washington, D.C.: American Sociological Association Resources Center.

1989   *Sociological Practice: The Development of Clinical and Applied Sociology*, 7.

Glass, John
    1979   Renewing an old profession. *American Behavioral Scientist* 23(3):513–30.
Glick, Clarence E.
    1989   Telephone Interview. January 19.
Gordon, Judith B.
    1989   Notes on the history of clinical sociology at Yale. *Clinical Sociology Review* 7:42–51.
Hillyer, Jane
    1926   *Reluctantly Told.* New York: The Macmillan Company.
Horn, Margo
    1989   *Before It's Too Late: The Child Guidance Movement in the United States, 1922–1945.* Philadelphia: Temple University Press.
Hug, Elsie
    1965   *Seventy-Five Years in Education: The Role of the School of Education, New York University, 1890–1965.* New York: New York University Press.
    1990   Interviews. November 16, 21, and December 5.
Hunter, Herbert M.
    1988   The clinical sociology of George Edmund Haynes (1880–1960). *Clinical Sociology Review* 6:42–50.
Hyman, Anna
    1932   Letter to Louis Wirth. June 7. Louis Wirth Collection. University of Chicago, Department of Special Collections. Box 28, Folder 11.
Lee, Alfred McClung
    1944   Sociology, clinical. P. 303 in H. P. Fairchild (ed.), *Dictionary of Sociology.* New York: Philosophical Library.
    1979   The services of clinical sociology. *American Behavioral Scientist* 22/4 (March/April): 487–512.
    1982   The long struggle to make sociology useful. *Public Relations Journal* 38/7 (July): 8–11.
    1988b   *Sociology for People: Toward a Caring Profession.* Syracuse: Syracuse University Press.
    1989   The convergence of science and humanistic intervention: Practitioners in the sociological struggles. *Sociological Practice*, 7.
New York University, School of Education
    1929–30   *Bulletin.*
    1930–31   *Bulletin.*
    1931–32   *Bulletin.*
    1932–33   *Bulletin.*
    1933–34   *Bulletin.*
    1940–41   *Bulletin.*
    1941–42   *Bulletin.*
New York University, Department of Educational Sociology and Anthropology
    n.d.   A Brief History of the Department of Educational Sociology and Anthropology from 1923–1969. New York University Archives. File: Department Histories—SEHNAP (School of Education, Health, Nursing and Arts Professions): Educational Sociology.
Shaw, Clifford Robe
    1930   *The Jack-Roller, A Delinquent Boy's Own Story.* Chicago: University of Chicago Press.

1931   *The Natural History of a Delinquent Career*. Chicago: University of Chicago Press.
Straus, Roger (ed.)
    1979   Special issue on clinical sociology. *American Behavioral Scientist* 22/4 (March/April).
Symons, Joseph
    1933   Student notes from sociology 473 (clinical sociology). University of Chicago.
Tulane Scraps
    1929   Head of Tulane child guidance clinic arrives. September 18. *Tulane Scraps*, vol. 17. Archives, Tulane University Library.
Tulane University Bulletins
    1928–29   Clinical sociology course description.
University of Chicago, Office of the Recorder
    1928–38   Instructors' Reports. University of Chicago, Department of Special Collections.
University of Chicago, University College
    1931–32   Supplementary announcement, Spring.
Winternitz, Milton C.
    1929   Medicine as social science. Address given at the dedication of the Social Science Building, University of Chicago. December 16. Yale University Archives, School of Medicine, Records of Dean. YRG 27-A-5-9. Box 174, Folder 3613.
    1930a   Clinical sociology section to be formed. Pp. 92–94 in report of the School of Medicine. Reports to the president of Yale University, 1928–29. *Bulletin of Yale University*, New Haven. Reprinted in *Clinical Sociology Review*, 1989.
    1930b   Practical Study of Social Relations: Plan for Graduate Department of Clinical Sociology at Yale. Report, 10 pp. Yale University Archives, School of Medicine, Records of Dean. YRG-27-A-5-9. Box 174, Folder 3608. Reprinted in *Clinical Sociology Review*, 1989.
    1931a   Report of the School of Medicine. Reports to the president of Yale University, 1929–1930. *Bulletin of Yale University*, New Haven.
    1931b   Clinical Sociology at Yale. Report, 7 p. Yale University Archives, School of Medicine, Records of Dean. YRG-27-A-5-9. Box 112, Folder 2604.
    1931c   Notes on clinical sociology. Yale University Archives, School of Medicine, Records of Dean. YRG-27-A-5-9. Box 112, Folder 2604.
Wirth, Louis
    1931   Clinical sociology. *American Journal of Sociology* 37:49–66.
    1932   Letter to Anna Hyman. June 17. Louis Wirth Collection, University of Chicago, Department of Special Collections. Box 28, Folder 11.
Zorbaugh, Harvey Warren
    1929   *The Gold Coast and the Slum: A Sociological Study of Chicago's Near North Side*. Chicago: The University of Chicago Press.
    1932   Mental hygiene's challenge to education. *Journal of Educational Sociology* 5 (February): 325–33.
    1939   Sociology in the clinic. *Journal of Educational Sociology* 12 (February): 344–51.
    1946   Letter to Ernest W. Burgess, University of Chicago, November 12. Ernest Burgess Collection, University of Chicago, Regenstein Library. Box 26, Folder 9.
Zorbaugh, Harvey Warren and Rhea W. Boardman
    1936   Salvaging our gifted children. *Journal of Educational Sociology* 10 (October): 100–8.

Lifetimes in Humanist Sociology

Elizabeth Briant Lee
Alfred McClung Lee
Drew University

ABSTRACT

Elizabeth Briant Lee and Alfred McClung Lee describe their family backgrounds, their dedication to humane values and their interest in alleviating social problems. The authors discuss the humanistic social science organizations they founded which were a reflection of their values.

Where do life-history recollections begin? With what should such a talk as this start?

We have professionally spent a lot of time studying life-history materials on people from many social levels and ethnic backgrounds. They always show us the extent to which people are products and parts of many on-going social processes. We cannot become acquainted with other people unless we know more about them than their daily routines and unusual social accomplishments. Where did they come from?

So we will not start our recollections at our important "blind" date in Oakmont, Pennsylvania, in the summer of 1926. We recall how much fun it was getting acquainted in the evening quiet of the local cemetery! A year later, Betty had finished her sophomore year. Al had graduated. He was making barely enough money to support the two of us. We got married.

But where did we come from? At various times between 1608 and 1837, our ancestors managed to survive the fever-ridden ships from northern European countries and the difficulties of finding a home and earning a living in this country. We do not know the names of all the approximately 250 immigrants from whom we are descended. They were Irish, Welsh, Scottish, French, Swedish, English, Danish, German, and Swiss. Older genealogies also mention Italian, Spanish, and Iroquois roots. So we are mongrels, and our charming and thriving grandchildren and our first great-grandson are even more so—both genetically and ethnically.

Betty's Briants were French Huguenots who settled for a while in Belfast after having been driven out of France. Then they fled from famine conditions in Ireland in the 1740s to the American frontier. Morgan Briant became the first European to drive a wagon through the Cumberland Gap into Kentucky. His son, William, married Daniel Boone's sister, Mary. William was killed by Indians in the American Revolution. Betty's father's mother, Clara, was a Jones whose Quaker ancestors emigrated from Wales in the 1740s. Her mother's parents, Eudora Cornelia Crane and Frank Scott Riley, were also descended from early arrivers. The Rileys had been Dublin merchants. In this country they were farmers and then got involved in railroad management. The Cranes were among the founders of New Haven, Connecticut, and then of Elizabeth, New Jersey. They were Congregationalists or Baptists. As they moved west to West Virginia, they were chiefly merchants and were politically and commercially conservative.

Since all of Betty's grandparents had died before she was born, she knows little of their personal characteristics. In contrast with Al's situation, too, she had only occasional contact with relatives because shortly after their marriage in 1901 her parents moved to Pittsburgh, somewhat distant from their West Virginia home. In addition, both of Betty's father's brothers and his only sister, as well as her mother's only sibling, her brother, went to the West Coast to seek their fortunes, then a popular move.

So far as he knows, Al is not at all related to the Robert E. Lee family. His immigrant ancestor, Robert, lived in a farmhouse in Norwell, Nottinghamshire, until Oliver Cromwell's troops destroyed that royalist hotbed. This convinced the Lees that they should migrate. When they settled in Long Island at Hempstead, they were at first Episcopalians. They became Presbyterians, and this dissent from the Church of England forced them to move to Yorktown Heights well north of New York City and the environs controlled by the Anglican ecclesiastics. As Dissenters, the Lees willingly fought in what King George III called "the Presbyterian war." George Washington's army was at least two-fifths Irish Dissenters or Presbyterians. Shortly after the Revolution, Al's ancestors became and married Quakers.

About 1811, Caleb Lee walked from his parents' farm in Yorktown Heights to become an apprentice to a merchant tailor in Pittsburgh. He and his wife, who was also a birthright Quaker, were among the founders of the First Baptist Church of Pittsburgh. Their fifteen children included George who, much to his father's eventual disillusioned disgust with clergy and churches, became a Baptist minister. George, Al's grandfather, married the daughter of a Presbyterian clergyman and changed to preaching that faith. But George was also in politics and in business. He needed to be. He and his wife, Rebecca Gilchrist McClung Lee, had and raised ten children, all of whom they sent to teachers' training or other types of advanced schools.

Al's other grandfather was a devout atheist, highly critical of theology and of churches which he called "temples of ignorance and superstition." He was an attorney and politician. Al's parents decided to get married in an Episcopal church and to be members of that denomination in order to avoid church-family involvements with the Presbyterians.

Our four parents were born after the Civil War into modest and struggling middle-class families. They deeply involved themselves in church and in other community organizations. Betty's parents even organized a Baptist church in Sheraden, the Pittsburgh area in which they lived. This required effort and dedication over many years. Both mothers were trained as stenographers and served as often as they could in paid positions as secretaries. This helped them to carry out the family obsession with higher education for their children. They both agitated actively for better educational opportunities and for women's rights. The fathers were opposed to militarism, to war, and to imperialism, and they were active in their churches and in such ritualistic lodges as the Masons, Elks, and the Knights of Pythias. The fathers dedicated themselves to their professions, and tried to help with such efforts as the Boy Scouts.

William Wolfer Briant, Sr., Betty's father, started out as a telegrapher and a reporter of sports and racing events for newspapers, but then he developed into a personnel manager for the Jones & Laughlin Steel Corporation in Pittsburgh.

Alfred McClung Lee, Sr., graduated from the State Normal College at Indiana, Pennsylvania, taught public school for several years, and then decided that he wanted to follow in the footsteps of his McClung uncles and his older brother and become an attorney. He supported himself as a student in the University of Pittsburgh Law School by serving as a reporter for several of the city's daily newspapers.

In our capitalistic society, both of our fathers were torn between the social welfare commitments with which they were raised and the opportunistic and exploitative pressures of their employers or clients. This led Al Lee, Sr., through bankruptcy and many difficult and unprofitable legal proceedings in behalf of

victims of exploitation and suppression. He especially enjoyed serving as a scoutmaster. It led Bill Briant, Sr., eventually to being replaced in the steel plant's personnel work by a relative of the Laughlins with a more capitalistic approach to human problems. So Betty's father spent his last years as a farmer and as an agitator for socialism.

Both of our mothers, Adah May Riley Briant and Edna Hamor Lee, also were disturbing and independent activists who provided us with useful models. That was especially true after they had the right to vote in 1920. They refused to accept rationalizations for society being as it is. Far from being either socialists or communists, they did what they could to help people with problems in their communities. Even before they could vote, they organized women's clubs, church social welfare projects, and demonstrations before courts, legislative bodies, and school boards. Year after year they made useful differences in their communities' lives.

All four of our parents were committed to higher education. They deprived themselves in many ways to help us and our brothers—Betty's two and Al's one, for we had no sisters—to acquire advanced education. Betty's brothers thus accumulated an M.D. and a D.D.S. in addition to her Ph.D. in sociology and anthropology. Al's brother earned a Ph.D. in physics to add to his own Ph.D. in sociology and anthropology.

In view of our backgrounds, it is little wonder that we found our way to clinical or applied or humanist sociology. Friends who know our backgrounds can see how that discipline offered us the kind of methods and perspectives with which to try to pursue interests in which we have been involved since our teen years and in which our four parents found their chief interests and concerns. Our lives have been further enriched through our experiences in rearing our two sons, with all the attendant difficulties and joys.

In view of those backgrounds, and also in recognition of the desirability of having some degree of community life in our anonymous urban areas, we experimented a lot with possible church connections. We have finally come to belong to a Unitarian church and a Quaker meeting as frankly agnostic members of each. Fortunately, neither of those requires a commitment to a creed.

But then there are problems with what humanist sociology means to others and to us. What is humanism? What is sociology? We are not sectarian humanists, and we have doubts about the utility and accuracy of a great deal of the literature labeled sociological.

We feel that since our high school days, we have been stimulated to discover and to serve humane goals. Aided by family problems and public events, we have sought to search out and understand the nature of people's relations with one another and with the general social environment. In these efforts, we have

sometimes found that we were mistaken, misled, or confused, but we have constantly tried to discover our errors and blunders, those of others, and tried to moderate or correct them. In all this, we had no holy writ to guide us. We could just do what we and our friends and associates might do to sift what appeared to be the most dependable examples of human experience.

We are proud of the idealistic but non-sectarian nature of the two humanist social scientific organizations that we started. Both the Society for the Study of Social Problems (SSSP), since 1950, and the Association for Humanist Sociology (AHS), since 1975, have exhibited broad interdisciplinary concerns. They have both attracted many creative and constructive social scientists to their conventions and publications. The Sociological Practice Association (SPA), which we helped to found in 1978, supplements both SSSP and AHS. Some have tried to identify the AHS with a sectarian religious humanism, such as is represented by the American Humanist Association, but AHS presidents and editors have brought a stimulating range of viewpoints to their leadership in the organization.

The humanist sociologists with whom we like to associate come from a range of disciplinary and religious backgrounds. These include people who might be labeled Jews, Roman Catholics, Muslims, Protestants, Agnostics, Atheists, or whatever, but whose concerns are similarly dedicated to an open and hopeful search for humane problems, questions, answers, and strategies. They and we view with anxiety the mounting and discouraging human crises, but we all retain what optimism and drive we can toward finding helpful strategies. This makes our living, even in the ninth decades of our lives, challenging and worthwhile.

Since we chose sociology as our professional path, why did we become so dissatisfied with its principal organization, then called the American Sociological Society (ASS), later suitably renamed the American Sociological Association (ASA)? Actually, our discontent with the field began in graduate school at the University of Pittsburgh and then continued at Yale University. We were intrigued by the field and its possibilities, but too many of our professors and texts and those in control of the ASS had concerns we looked upon as diverting. They were concerned about sociology not appearing to be "scientific" enough, not sufficiently resembling physics or chemistry. They wanted to be super-objective, highly quantified in their facts. What findings they revealed, they wanted to be uncontestable. And they talked on and on at their meetings about what sociology might be and about the philosophy of sociology. They had long rejected social work as "band aid" and inconsequential, long voted down any resolution concerned with current political and social issues offered at an annual business meeting. In contrast, we wanted to perceive and to understand social realities as they happened, as they can be seen by participant observers, and to contribute therapeutically to social welfare. Cross cultural and social historical

research had long been making disturbing and useful contributions not well absorbed into sociology.

We were not at all alone in this dissatisfaction, and we proceeded to bring together as many as we could who wanted to refocus the discipline on studies of realities, actual social problems, and on procedures for trying to cope with them for broad social benefit. It was the sort of emphasis we had demonstrated in our pre–1950 books on propaganda, race riots, the mass media, and then our *Principles of Sociology* and *Social Problems in America.*

The Society for the Study of Social Problems (SSSP) was an organization for which the time was ripe. We are happy with the tremendous influence it has had on the literature of the field. As one would expect, however, the organizationally ambitious who came to occupy its official positions were not always as independently creative as many of us would have liked. "Establishment thinking" and commercially rewarding case-making are all too tempting to too many. For some, the presidency of the SSSP became little more than a possible stepping stone toward the presidency of the ASA! Fortunately, the independence of the organization and the needs it fulfills keep it from succumbing to the temptations that continue to define the ASA's policies and procedures.

Twenty-five years after we got the SSSP under way, we felt another pressing need for organizational experimentation. We did not want to change the SSSP, but we felt it needed to be supplemented by a society that would more clearly and frankly be dedicated to humane values and to efforts to alleviate social problems. With the ASA declining in membership, fortunately such other outfits as the Sociological Practice Association, the sociological liberation movement, the autonomous regional societies, the Association for Humanist Sociology, and the Society for the Study of Social Problems keep the discipline alive and well and exciting—even to those who are now so antique!

Selected Works by Alfred McClung Lee and Elizabeth Briant Lee

Compiled by Jan M. Fritz
California State University, San Bernardino

Lee, Alfred McClung

1942   Subversive individuals of minority status. *The Annals of the American Academy of Political and Social Science* 223 (September): 162–72.

1943   Public relations counseling as institutional psychiatry. *Psychiatry* 6/3 (August): 271–76.

1944a   Sociology, clinical. P. 303 in H. P. Fairchild (ed.), *Dictionary of Sociology*. New York: Philosophical Library.

1944b   Techniques of social reform: An analysis of the new prohibition drive. *American Sociological Review* 9/1 (February): 65–77.

1945a   The analysis of propaganda: A clinical summary. *American Journal of Sociology* 41/2 (September): 126–35.

1945b   Interest criteria in propaganda analysis. *American Sociological Review* 10/2 (April): 282–88.

1945c   Public opinion in relation to culture. *Psychiatry* 8/1 (February): 49–61.

1946   The press in control of intergroup tensions. *The Annals of the American Academy of Political and Social Science* 244 (March): 144–51.

1947   Sociological theory in public opinion and attitude studies. *American Sociological Review* 12/3 (June): 312–23.

1950   Can the individual protect himself against propaganda not in his interest? *Social Forces* 29/1 (October): 56–61.

1954   Sociologists in an integrating society: Significance and satisfaction in sociological work. *Social Problems* 2/2 (October): 57–66. Presidential address before the Society for the Study of Social Problems.

1955   The clinical study of society. *American Sociological Review* 20/6 (December): 648–53.

1965   Items for the agenda of social science. Pp. 421–28 in Alvin Gouldner and S. M. Miller (eds.), *Applied Sociology*. New York: The Free Press.

1966   *Multivalent Man.* New York: George Braziller.

1973   *Toward Humanist Sociology.* Englewood Cliffs, N.J.: Prentice-Hall, Inc.

1978   *Sociology for Whom?* New York: Oxford University Press.

1979   The services of clinical sociology. *American Behavioral Scientist* 23/3 (March-April): 487–512.

1982   The long struggle to make sociology useful. *Public Relations Journal* 38/7 (July): 8–11.

1983   *Terrorism in Northern Ireland.* Bayside, N.Y.: General Hall, Inc.

1986   *Sociology for Whom?* 2d ed. Syracuse, N.Y.: Syracuse University Press.

1988   *Sociology for People: Toward a Caring Profession.* Syracuse, N.Y.: Syracuse University Press.

1991a   Steps taken toward liberating sociologists. Pp. 28–42 in Martin Oppenheimer, Martin J. Murray, and Rhonda F. Levine (eds.), *Radical Sociologists and the Movement: Experiences, Lessons, and Legacies.* Philadelphia: Temple University Press.

1991b   Public policies and clinical sociology. Pp. 165–80 in Howard Rebach and John Bruhn (eds.), *Handbook of Clinical Sociology.* New York: Plenum.

Lee, Alfred McClung, and Norman Daymond Humphrey

1943   *Race Riot.* New York: The Dryden Press, Inc.

Lee, Alfred McClung, and Elizabeth Briant Lee

1939   *The Fine Art of Propaganda: A Study of Father Coughlin's Speeches.* New York: Institute for Propaganda Analysis and Harcourt, Brace and Company, 1939; Reissued in 1965, Xerox Education Division, University Microfilms, Ann Arbor, Michigan; Reissued in 1972 with new introductory essay, New York: Octagon; Reissued in 1979, San Francisco: International Society for General Semantics.

1941   Table I: Number of dailies and size of towns; Table II: Competition situation in the daily newspaper field; Table III: Cities with competing daily newspapers, 1930 and 1940. Washington: Federal Communications Commission. Mimeographed. July 23. No. 52296.

1961a   Che cosa accade agli schemi di vita familiare negli stati uniti [What things are happening to the ways of family life in the United States]. An article based on chapters II and III of *Marriage and the Family. Quaderni di Sociologia* 39 (Winter): 3–20.

1961b   *Marriage and the Family.* Revised edition in 1967. New York: Barnes and Noble.

1974   The Society for the Study of Social Problems: Visions of its founders. *SSSP Newsletter* 5/1 (Fall 1974): 2–5.

1984   Clarence Marsh Case (1874–1946). *The Humanist Sociologist* 9/1 (January): 7–8.

1988   An influential ghost: The Institute for Propaganda Analysis, 1936–1942. *Propaganda Review* (Winter): 10–14.

Lee, Elizabeth Briant

1957   Editorial and publications committee. Report of the Committee Chair, Society for the Study of Social Problems. *Social Problems* 4 (1957): 277.

1959   As the twig is bent. *Fellowship* 25/5 (March 1): 21–24.

1978   Social factors making for eminence among American women social scientists. Presidential address given before the Association for Humanist Sociology annual meeting, October 21, 1978, South Bend, Indiana. Abstract in *Sociological Abstracts,* supplement 85, 78S09268 (October 20–22): 326.

1979   Working proposals. Report of the Chair of the Committee on Internal Structures. *Newsletter of the Association for Humanist Sociology* 4/3 (September 7): 5–7.

1980   A history of women's participation in the Eastern Sociological Society. *SWS Network* 10/2 (July): 5–6.

1981a   Liberated women and liberating education. Presented at a conference on the mission of higher education, SUNY New Paltz. January 30, 1981. Unpublished manuscript.

1981b   Sociologists' need for public relations. Presented at the Eastern Sociological Society annual meeting. Unpublished document.

1981c   Thoughts about present-day American middleclass marriage and family living. *The Humanist Sociologist* 6/3 (September): 13–14.

1982   Revisions for ethics code. Report of the chair of the Clinical Sociology Association Ethics Committee. *Clinical Sociology Newsletter* 5/12 (Spring): 10.

1984a   American women: Changing relations between sex and eminence before 1960. Paper presented at the second annual New Jersey Research Conference on Women. May 22. Unpublished manuscript.

1984b   Women humanist sociologists in the service of social change. Presented at the annual meeting of the Society for the Study of Social Problems. August 15. Unpublished manuscript.

1985a   Early famous American women: All born in Ireland. Pp. 16–18 in Elizabeth Logue (ed.), *Irish Heritage Week: 1985*. Clifton, N.J.: Irish American Unity Conference, New Jersey Branch.

1985b   A concern. Statement by a past president for the tenth anniversary celebration of the Association for Humanist Sociology, Atlanta, Georgia, November 9. Unpublished document.

1986   Coughlin and propaganda analysis. *Humanity & Society* 10/1 (February): 25–35. Abstract No. 86Q7866 in *Sociological Abstracts* 34/4 (October 1986): 1047.

1988   Mary Ellen Richmond (1861–1928). *Humanity & Society* 12/2 (May): 160–65.
          How some women became eminent social scientists. *Humanity & Society* 13/1:16–28. Presidential address delivered to the third annual convention of the Association for Humanist Sociology on October 21, 1978.

1989   How some women become eminent social scientists. *Humanity & Society*. 13/1:16–28. October 21, 1978.

Lee, Elizabeth Briant, and Alfred McClung Lee

1976   The Society for the Study of Social Problems: Parental recollections and hopes. *Social Problems* 24/1 (October): 4–14.

1979   The fine art of propaganda analysis—then and now. *Et Cetera* (Summer): 117–27.

1981   Two clinicians tandem in social action. *Clinical Sociology Newsletter* 4/10 (Fall): 3–4.

1985a   A home for the ethical humanist. Letter to readers. *Friends Journal* 31/2 (February 1): 21.

1985b   Two sociologists in search of action. Adapted from a 1981 *Clinical Sociology Newsletter*. P. 20 in Beth Hess, Elizabeth Markson, and Peter Stein, *Sociology*. New York: Macmillan Publishing Co.

1985c   Melting pot discriminates. Letter to readers. *Friends Journal* 31.10 (June): 19.

1985d   Some thoughts on SSSP's mission. *SSSP Newsletter* 17/1 (Fall): 9–12. Abstract in *Sociological Abstracts* 33/5, S17426 (1985): 1764.

1986   Propaganda analysis in 1937–42—and now? *Quarterly Review of Doublespeak* 12/2 (January): 2–4.

1987   Teaching humanist sociology: An introduction. Pp. 1–4 in Martin D. Schwartz (ed.), *The Humanist Sociology Resource Book*. Washington: ASA Teaching Resources Center.

1988a   Developing a humanist perspective. Pp. 295–304 in Robert Cipriani and Maria Immacolata Macioti (eds.), *Omaggio a Franco Ferrarotti*. Rome: Siares.

1988b   The continuing values of SSSP. *SSSP Newsletter* 19/1 (Winter): 4–5.

1989   Humanist challenges to sociologists. *SSSP Newsletter* 20/2 (Summer): 3–5.

Lee, Elizabeth Briant, and Alfred McClung Lee (eds.)
    1949   *Social Problems in America: A Source Book.* New York: Henry Holt and Company.
Rose, Arnold (ed.), and assistant editors Mabel Elliott, Hornell Hart, Jerome Himelhoch, Samuel
Koenig, Elizabeth Briant Lee, Wayne Neely, Lowry Nelson, and Preston Valien
    1955   *Mental Health and Mental Disorder.* New York: W. W. Norton.
Pfautz, Harold, Ray Abrams, Elizabeth Lee, and S. M. Miller
    1956   The climate of opinion and the state of academic freedom. *American Sociological
            Review* 21:353–57.

Personality Disorders or Role Negotiation Problems?

Melvyn L. Fein

ABSTRACT

Many of the "personality disorders" defined by the DSM-III and DSM-III-R are really "role negotiation problems." Without fair, problem-solving oriented negotiations, people find it difficult to construct satisfying ways of life. This, for example, is true of passive-aggressive and histrionic strategies, and, if not recognized as such, interferes with effective clinical interventions.

Personality Disorders?

"Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of social and personal contexts. It is only when *personality traits* are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective stress that they constitute *Personality Disorders.*"

Thus does the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, 1987) define personality traits and personality disorders. This nosological system, which has become the bible of mental health professionals, takes special care to recognize the importance of personality problems, even going as far as to acknowledge that they are different from many other so-called mental disorders. It does so by placing them on a separate "axis" and giving them a unique status of their own. What it does not do, however, is emphasize the social and relationship character of these difficulties.

The DSM-III does state that personality traits include enduring patterns "relating to" the "environment" and are exhibited in "social contexts," but these are mentioned almost in passing. Many prominent psychological theorists, however, go a bit farther and, together with Theodore Millon (1986), bemoan the tendency of psychotherapists to "focus . . . on the patient's internal characteristics alone." Millon reminds his colleagues that "internal and external elements are inextricably linked" and that "intrapsychic structures and dispositions . . . prove functional or dysfunctional depending on their efficacy in specific interpersonal, familial, or social contexts." He would almost surely accept the insights of Karen Horney (1945) when she asserted that neuroses are grounded in inter- and intrapersonal conflicts.

Nevertheless, psychologists and psychotherapists have tended to concentrate on the personal characteristics of their subjects. Since the essential subject matter of these professionals is the human psyche, they tend to give short shrift to relationship variables. In fact, they have not noticed that the essence of the so-called personality disorders is not to be found in "perceiving" or "thinking," or that these "disorders" do more than cause a "significant impairment in social or occupational functioning." Specifically, they fail to appreciate that these behavior patterns are actually precipitated by social factors. To be more precise, it has not been recognized that personality disorders are more accurately described as "role negotiation" difficulties than "personality" ones.

A Role Negotiation Perspective

Social roles constitute a fundamental framework for social interaction (Fein, 1990). The various roles that human beings play structure their relationships with one another and give substance to their lives. Unless people have satisfactory roles that enable them to meet their fundamental needs, they cannot be happy. It is as spouses and parents that most of us experience love, and without these roles we would be adrift in a world peopled with millions of anonymous strangers. Even on a personal level, social roles are necessary to give meaning to life. That someone is a "caretaker," a "scapegoat," or a "family genius," may provide the linchpin of his existence, and even if these roles are stressful, they at least provide a direction for personal endeavors (Scarf, 1987).

But as important as social roles are, they do not spring into being fully formed, like Athena from the head of Zeus. No, social roles are constructed phenomena, and more significantly, they are constructed in social interaction (Sarbin and Allen, 1968; Turner, 1968, 1978). It is in the interpersonal negotiations, which form a central part of human experience, that people determine who will play what role and how they will play it (Kohn, 1969; Kohn and Schooler,

1983). Demands and counterdemands run throughout life and give it its orga-nized character (Biddle, 1979). These demands create and maintain roles; they provide the boundaries within which individual decisions are made and personal directions are elaborated. As mundane as it may seem, it is in fights about who will take out the garbage that the nature of a role such as husband or child is decided.

The ubiquity of role negotiations, and their significance in establishing en-during patterns of interaction, is what makes them so pivotal to human happi-ness. If role negotiations go well, they can eventuate in relationships that enable people to meet their needs for safety, love, and respect (Maslow, 1954). Indi-viduals can, for instance, build honest and intimate relationships in which they sensitively enhance each other's life chances. On the other hand, their role ne-gotiations may be coercive, in which case they can be used to force people to behave in ways which are contrary to their interests. A child might, for exam-ple, be bullied into the role of family "scapegoat" (Ackerman, 1958), and, in the process, be prevented from being either safe or loved.

It takes fair negotiations to produce satisfying social roles. When these patterns are systematically unfair, they result in distorted and painful roles. Specifically, it is when role negotiations are "maladaptive" and "inflexible" that people are forced into dysfunctional and stressful patterns of living (Frank, 1973; Grinker, 1961). Thus, it is often a person's role negotiation strategy, and not his personality per se, that is responsible for his personal distress. One's social world, rather than one's psychic quirks, is the locus of fault, and ultimately where relief will be found.

Negotiations: Fair and Unfair

We will shortly be examining particular examples of role negotiation prob-lems, but first we must determine how negotiations can be fair or unfair. Dean Pruitt's (1981, 1983) analysis of negotiation behavior constitutes an excellent starting place. He distinguishes between four basic strategies that can be adopted within a negotiation. His "dual concern" model proposes that someone can pur-sue (1) only his own interests, (2) primarily the interests of his partner, (3) both his interests and those of his partner, or (4) the interests of neither. If the first of these options is embraced, a person might rationally engage in excessive "con-tending"; coercion would then be regarded as a reasonable method for achieving his ends. If the second alternative is adopted, he would do well to yield and allow his partner to have whatever he wishes. The fourth option recommends a strategy of inaction, for if neither's interests count, it doesn't matter what a person does. It is obviously only the third alternative, namely considering the

interests of both partners, which is the moderate course. It is the one that favors a problem-solving approach to interpersonal disputes, and, one might add, is the one most likely to result in "fair" solutions.

In role relationships people work together to achieve ends that will hopefully satisfy both. Of course, not all relationships can, or should be, absolutely fair, but it is imperative that many should be. Without a reasonable degree of fairness, people feel cheated and misused, and if they can, strive to redress their grievances. This is especially true of intimate relationships, which, if not constructed on a foundation of trust, rapidly disintegrate into nothingness. Even unequal relationships, such as that between supervisor and supervisee, must include more than a modicum of fairness, for otherwise they approach that of master and slave, and will be rife with rebellion and inefficiency.

But many people approach their interpersonal encounters with a spirit of less than fairness. They do not perceive themselves as engaged in an act of problem solving, but as asserting dominance, or protecting themselves from it. Theirs is not a world of partnerships, but one bathed in savagery and strife. For them, the inevitable conflicts of role negotiations are not open to peaceful resolution and, of necessity, involve a battle to the death.

This conflict-gone-awry is an implicit theme of many personality and psychotherapy theorists. Thus, it is present in the polarities which Millon (1986) uses to explain the varieties of personality dysfunction. His distinction between the self and other as a source of suitable reinforcement comes close to recognizing the importance of interpersonal unfairness, as less obviously do his dualities of pleasure/pain and active/passive. More clearly identifying the role of conflict is Horney's (1945) classification of people as moving "toward," "against" and "away from" others. Her model is very similar to Pruitt's when it distinguishes between yielding, contending, and inaction strategies.

Examples from the DSM-III

To discern how patterns defined by the DSM-III (1980) as personality disorders actually reflect role negotiation problems, one can do no better than to review the DSM-III itself. Since it enumerates twelve personality disorders, it is impossible within the compass of one paper to treat them all. Therefore, only two are examined here. These will be the "passive-aggressive" personality and the "histrionic" personality. The first has been chosen because it seems obviously related to negotiation strategies. On the face of it, it describes a yielding (or perhaps inactive) strategy, but on closer inspection will be found to involve excessive contending. The second has been chosen for its historic interest. Hysteria was Freud's entree into psychotherapy (Breuer and

Freud, 1957; Freud, 1953–1974), and it is interesting to note that a problem he originally treated as medical is, in truth, interpersonal, and, more particularly, negotiational.

Passive-Aggressive Personality

The passive-aggressive is described by the DSM-III as exhibiting:

A. Resistance to demands for adequate performance in both occupational and social functioning.
B. Resistance expressed indirectly through at least two of the following:
   1. procrastination
   2. dawdling
   3. stubbornness
   4. intentional inefficiency
   5. "forgetfulness."
C. As a consequence of (A) and (B), pervasive and long-standing social and occupational ineffectiveness (including roles of housewife and student), e.g., intentional inefficiency that has prevented job promotion.
D. Persistence of the behavior pattern even under circumstances in which more self-assertive and effective behavior is possible.

"Passive-aggressive" is one of the favorite epithets of many psychotherapists (Spotnitz, 1976). It is often used pejoratively to describe difficult clients who resist the ministrations of their therapists. This sort of client is often categorized as "manipulative" and "resistant." Such a person is seen to be fighting in an unfair way, obtusely frustrating the professional in his attempts to effect a "cure." The language used is explicitly that of conflict, and the client's behaviors are castigated as iniquitous. Indeed, his very style of interacting becomes the object of therapeutic attention.

The passive-aggressive client, in effect, engages in role negotiations with his therapist (Fein, 1990). The two are embroiled in a contest to determine how the client will relate with his helper and with significant others in his life space. But in this negotiation, the client is perceived as inappropriately contentious. It is alleged that instead of allowing the professional to control their interchanges, the client surreptitiously asserts his own will. The therapist understands himself as an expert whose job is to guide inadequate others into behavior patterns that they will find more fulfilling, while the client, contrary to his own overt request for help, attempts to move in a more independent direction.

No wonder therapists become frustrated and use diagnostic categories as labels of abuse.

Invoking the term "passive-aggressive" in a tendentious fashion may be an act of unfairness, but it is often a reaction to the unfairness of a client. Procrastination, dawdling, stubbornness, intentional inefficiency and "forgetfulness" can be extremely infuriating. They are, in fact, ways of resisting another person, and are all the more repugnant for being covert. Rather than saying "no" directly, the passive-aggressive merely drags his feet. On the surface, he may seem inactive, but this inactivity is purposive—the purpose is to defeat the other. In a sense, this strategy is eminently coercive, because it is so elusive. It is very difficult to influence a person who is ostentatiously doing nothing. When one accuses him of disagreeing with one's suggestions, he purses his lips and mutely proceeds upon his business. He will not allow us to win, or to make a difference, because he persistently refuses to acknowledge that we even have a bone of contention.

People become passive-aggressive, not because they intend to be obnoxious, but because they want to protect themselves. When children are raised by excessively coercive parents, they may have no recourse but to subterfuge. If a parent brooks no backtalk and no bargaining, how else can a child exercise control of his destiny? If direct resistance to parental orders regularly invites punitive oppression, what other strategy than secrecy is available? In such a circumstance, silent resistance may have the virtue of producing results, without inviting a beating.

The trouble is that this negotiation strategy does not allow for cooperative negotiations. If two partners are to collaborate in constructing roles that are mutually beneficial, they must problem-solve. But to problem-solve, they must put their interests and desires on the bargaining table. Misdirection and ostensible passivity short-circuit this process. They prevent an open dialogue which is the best hope of innovative and responsive solutions. No wonder they lead to the social ineffectiveness which the DSM-III finds so objectionable.

Histrionic personality

The DSM-III describes the histrionic personality as engaging in:

A. Behavior that is overly dramatic, reactive and intensely expressed, as indicated by at least three of the following:
   1. self dramatization, e.g., exaggerated expression of emotion
   2. incessant drawing of attention to oneself
   3. craving for activity and excitement

    4. overreaction to minor events

    5. irrational, angry outbursts or tantrums

B. Characteristic disturbances in interpersonal relationships as indicated by at least two of the following:

    1. perceived by others as shallow and lacking genuineness, even if superficially warm and charming

    2. egocentric, self-indulgent, and inconsiderate of others

    3. vain and demanding

    4. dependent, helpless, and constantly seeking reassurance

    5. prone to manipulative suicidal threats, gestures, or attempts.

On the face of it, the histrionic personality is not an incompetent role negotiator, but an abhorrent, demanding, and self-involved boor. His theatricality and dependence make him an unpleasant companion whom we would like to see develop some maturity. Our thoughts are inevitably drawn to the swooning Victorian ladies who sought their salvation on Sigmund Freud's psychoanalytic couch. Their husbands, and many of their physicians, treated them as superannuated children who must either be indulged or bullied into submission (Drinka, 1984). That they were deemed "sick" may have been little more than a comment on how uncomfortable was their presence (Szasz, 1961). But were these ladies (or their modern counterparts) merely being obnoxious, or did something else lurk behind their irritating surface? Why the exaggerated expression of emotions, the constant drawing of attention to oneself, or the overreaction to minor events? Why the shallowness, the egocentric self-indulgence, or the vain, demanding helplessness? Despite appearances, can it be that they were more than weak and unpleasant people? Perhaps their behaviors had a significance other than the obvious; perhaps they were in fact trying to achieve something important.

A clue may be found in the phrase "vain and demanding." It suggests a person who has a goal—in this case, someone who wants to be noticed and to make a difference. If indeed histrionics are "demanding," they may be engaged in negotiating, albeit in a manner that alienates their role partners. Self-drama and incessant drawing of attention to oneself indicate a need to be loved and, perhaps, respected. These maneuvers bespeak a person starved for interpersonal regard, but one who doesn't feel strong enough to attain it. We are reminded of Ibsen's *A Doll's House* and of the impotence and irrelevance to which Victorian housewives were often reduced. The epidemic of hysteria that Freud addressed may simply have been a sign of the poor negotiating situation in which these women found themselves.

Histrionic behaviors may actually be part of a role negotiation strategy of last resort, when other tools are not available. Moreover, these behaviors are especially associated with women because self-drama, overreaction to minor events, emotionality, tantrums, helpless dependence, and shallowness have historically been attributed to the role of female. Witness the ancient controversy about whether men may suffer from hysteria and the fact that this erstwhile medical disorder is named after the female womb (Veith, 1965). To designate the "histrionic personality" as a mental disorder is to impugn the negotiating techniques that many women have been forced to invoke. If their practices are unfair, and they often are, it is because the roles into which women have been thrust are often unfair. Excessive self-drama may be a form of coercion, but one which has been employed to counteract social demands which require women to be helpless, second-best citizens.

Aggressive self-drama and exaggerated emotions turn the female role on its head and use its implied helplessness as a weapon. These techniques trade on the fact that the strong man is not supposed to injure the weak woman. Tears and tantrums are a sign of her supposedly sex-linked fragility, and hence to attack her is forbidden. But if a man cannot use his advantages, then he is forced to comply with her wishes. He is put in a no-win situation, and this is the signature of coercion. Of course, the woman also loses because histrionic techniques prevent her from asking for what she wants in a way that will invite cooperation. Her partner may refrain from thrashing her, but he will not be inclined to honor or respect her. The techniques she uses may be designed to gain respect, but they only elicit a negative form of attention, one which is rarely satisfying.

Conclusion

To label histrionic negotiating techniques as a personality disorder is to place additional blame on people who are already having a difficult time making their lives work. Their ways of interacting certainly do cause them problems, but attributing them to disordered personal traits increases their burden. When, however, one recognizes that they are engaging in dysfunctional role negotiations, one doesn't have to try to change *them;* one only has to change their negotiation strategies. Instead of asking them to become different people, one can acknowledge the legitimacy of their goals and encourage them to institute strategies which do succeed. The fact that they desire to be safe, loved, and respected is no sin; it is what we all want. They only need more effective ways of achieving it.

If one examines the DSM-III's list of personality disorders, one notices that most of the entries clearly entail faulty role negotiation strategies. Thus the avoidant personality obviously engages in excessive inaction, while the antisocial personality indulges in excessive contending. Likewise, the narcissistic personality is unfairly coercive in a manner not unlike that of the histrionic, and the dependent personality is a champion yielder. Even the paranoid personality has negotiation problems in that he fights shadows and does so far too aggressively.

If clinicians are to implement productive interventions with those labeled as having "personality disorders," they will do well to recognize that these entail self-defeating negotiation styles. They will then be positioned to help their clients become problem-solvers, rather than ineffective contenders or yielders. By noticing that a social interaction has misfired, clinicians will be enabled to impart appropriate social skills and to do so in a nonjudgmental manner. As long as helping professionals exclude a social perspective from their attempts to assist people in pain, they will miss the essence of what causes the pain, and, however well meant, their interventions will bypass the real issue.

REFERENCES

Ackerman, N. W.
    1958   *The Psychodynamics of Family Life*. New York: Basic Books.
Alexander, F.
    1948   *Fundamentals of Psychoanalysis*. New York: W. W. Norton.
American Psychiatric Association Committee on Nomenclature and Statistics
    1968   *Diagnostic and Statistical Manual of Mental Disorders*, 2d ed. Washington, D.C.
    1980   *Diagnostic and Statistical Manual of Mental Disorders*, 3d ed. Washington, D.C.
    1987   *Diagnostic and Statistical Manual of Mental Disorders*, rev. 3d ed. Washington, D.C.
Ausubel, D.
    1967   Personality disorder is disease. In T. Scheff (ed.), *Mental Illness and Social Process*. New York: Harper and Row.
Biddle, B.
    1979   *Role Theory: Expectations, Identities and Behaviors*. New York: Academic Press.
Bloom-Feshbach, J., and S. Bloom-Feshbach (eds.)
    1987   *The Psychology of Separation and Loss*. San Francisco: Jossey-Bass Publishers.
Breuer, J., and S. Freud
    1957   *Studies on Hysteria*. New York: Basic Books.
Chess, S., and A. Thomas
    1986   *Temperament in Clinical Practice*. New York: Guilford Press. Cooley, C. H.
    1956   *Human Nature and the Social Order*. Glencoe, Ill.: The Free Press.

Drinka, G. F.
    1984   *The Birth of Neurosis: Myth, Malady and the Victorians*. New York: Simon and
                Schuster.
Fein, M.
    1988   Resocialization: A neglected paradigm. *Clinical Sociology Review* 6:88–100.
    1990   *Role Change: A Resocialization Perspective*. New York: Praeger.
Frank, J.
    1973   *Persuasion and Healing; A Comparative Study of Psychotherapy*. Baltimore: The
                Johns Hopkins University Press.
Freud, S.
    1953–1974 *The Standard Edition of the Complete Psychological Works of Sigmund Freud*.
                J. Strachey (ed.). London: Hogarth Press and Institute for Psychoanalysis.
Garbarino, J., C. J. Schellenbach, and J. Sebes
    1986   *Troubled Youth, Troubled Families*. New York: Aldine De Gruyter.
Garfinkel, H.
    1967   *Studies in Ethnomethodology*. Englewood Cliffs, N.J.: Prentice-Hall.
Grinker, R.
    1961   A transactional model for psychotherapy. In M. Stein (ed.), *Contemporary Psy-
                chotherapies*. New York: Free Press of Glencoe.
Horney, K.
    1945   *Our Inner Conflicts: A Constructive Theory of Neuroses*. New York: W. W. Norton
                Co.
Kohn, M.
    1969   *Class and Conformity: A Study in Values*. Homewood, Ill.: The Dorsey Press.
Kohn, M., and Schooler, C.
    1983   *Work and Personality: An Inquiry into the Impact of Social Stratification*. Norwood,
                N.J.: Ablex Publishing.
Maslow, A.
    1954   *Motivation and Personality*. New York: Harper and Row.
Millon, T., and G. L. Klerman (eds.)
    1986   *Contemporary Directions in Psychopathology: Toward the DSM-IV*. New York: The
                Guilford Press.
Millon, T.
    1986   A theoretical derivation of pathological personalities. In T. Millon and G. L. Kler-
                man (eds.), *Contemporary Directions in Psychopathology: Toward the DSM-IV*.
                New York: The Guilford Press.
Pruitt, D. G.
    1981   *Negotiation Behavior*. New York: Academic.
    1983   Strategic choice in negotiation. *American Behavioral Scientist* 27(22).
Sarbin, T., and V. Allen
    1968   Role theory. In G. Lindzey and E. Aronson (eds.), *Handbook of Social Psychology*.
                Reading, Mass.: Addison Wesley.
Scarf, M.
    1987   *Intimate Partners: Patterns in Love and Marriage*. New York: Random House.
Spotnitz, H.
    1976   *Psychotherapy of Preoedipal Conditions*. New York: Jason Aronson.
Straus, R. (ed.)
    1969   Clinical sociology. Special Issue, *American Behavioral Scientist* 22(4).

Stryker, S., and A. Statham
    1985   Symbolic interaction and role theory. In G. Lindzey and and E. Aronson (eds.),
                Handbook of Social Psychology, 3d ed. New York: Random House.
Sullivan, H. S.
    1953   *The Interpersonal Theory of Psychiatry*. New York: W. W. Norton Co.
Szasz, T.
    1961   *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New
                York: Dell.
Turner, R. H.
    1968   Role: Social aspects. In Sills (ed.), *International Encyclopedia of the Social Sci-
                ences*. New York: Macmillan.
    1978   The role and the person. *American Journal of Sociology* 84:1–23.
Veith, I.
    1965   *Hysteria: The History of a Disease*. Chicago: University of Chicago Press.
Wirth, L.
    1931   Clinical sociology. *American Journal of Sociology* 37:49–66, 167–94.

Clinical Sociology and Religion

C. Margaret Hall
Georgetown University

ABSTRACT

Although religious concerns are generally not clients' primary presenting problems in secular therapists' practices, religious beliefs and values can have a strong influence on clients' behavior and clinical progress. For this reason, knowledge about religion and its impact can be useful in intervention work.

Three case studies illustrate how sociology of religion can be a substantive resource in clinical sociology and sociological practice. In this paper, religion is defined as a belief system of denominational, sectarian or secular values which explains natural and supernatural phenomena.

As the concept of a supreme being is central in most Western belief systems, the three clients' perceptions of their relationships with a supreme being are examined. Clients' concepts of God are used to demonstrate the process by which clinical strategies can increase the meaningfulness of clients' choices of secular and religious values and their awareness of the consequences of holding specific beliefs for their everyday behavior.

The three clinical examples are based on life history data of contrasting patterns of behavior resulting from individual allegiances to different religious belief systems. These contrasts are summarized as patterns of "Deference/Fatalism," "Self as Equal to God," and "Copartner with Powerful God." It is proposed that sociology of religion can effectively inform principles and strategies for clinical intervention, as well as strengthen and enrich basic propositions of clinical sociology.

Religion was intensively studied by nineteenth century and early twentieth century sociologists, as well as by philosophers before that time (Birnbaum

and Lenzer, 1969). Whereas Marx viewed religion negatively—as a tool of exploitation used by the upper classes, the opiate of the masses, and false consciousness—Durkheim documented religion as both a means and foundation of social solidarity (Durkheim, 1965). Weber later challenged the Marxian hypothesis that religion prevents social change by delineating the innovative role played by Protestantism in the development of capitalism (Weber, 1958).

These theories have relevance for both contemporary sociology and clinical sociology. Issues of social and individual change are central in these disciplines. As social values have changed at an accelerated pace in the last decades, questions continue to be raised about the role of religious beliefs and values in promoting and/or inhibiting change, and in the resulting quality of life.

The major contribution of clinical sociology within contemporary sociology is that it provides a broad, substantive base and conceptual context for intervention work at different levels of social organization (Clark, 1990). Clinical sociological perspectives range from individual reflection to community change (Glassner and Freedman, 1979). This orientation is innovative in that it allows for the consideration of more individual and social facts in assessing behavior than traditional mental health disciplines.

In contrast to general sociological concerns with the influence of all beliefs and values on everyday behavior, this article examines the effects of selected aspects of religious beliefs and values on interaction and clinical outcomes. Although religious concerns are generally not clients' primary presenting problems in secular therapists' practices, religious beliefs and values can markedly affect clients' behavior and clinical progress. For this reason, knowledge about religion and its impact can be useful in intervention work. In this study, specific contributions of sociology of religion to clinical sociology and sociological practice are outlined, in order to more precisely assess the appropriateness of working with religious beliefs and values in therapy.

In sociology of religion, in general, and in this study, specifically, religion is defined as a belief system of denominational, sectarian, and secular values which explains natural and supernatural realities (Birnbaum and Lenzer, 1969). The three case studies selected illustrate ways in which clinical discussions and analyses of clients' beliefs and values can increase their autonomy and effectiveness in everyday behavior and goal attainment.

A focus on religion links micro- and macro-sociological perspectives (Carbine, 1980; Paloutzin and Ellison, 1982; Alexander, Giesen, Munch, and Smelser, 1987). The contrasting beliefs in God specified in the following case studies demonstrate the manner in which the qualities and intensity of the values underlying these beliefs create significant consequences for self-concepts, identities, world views, and behavior (Meadow, 1980; Caughey, 1984). The

contrasting beliefs represent different perceptions of a supernatural power and each person's relationship with that supernatural power.

Clinicians can be more effective when they recognize that denominational and sectarian beliefs characteristically have contrasting degrees of salience for their adherents (Buber, 1958; James, 1961; Rosenberg and Turner, 1981). Sociologists of religion proffer that impersonal or detached formal behavior is typical of denominations, while intense religiosity or devotional fervor characterizes the more intimate interaction of sects (Ortony, Clare and Collins, 1988). Clinical data suggest that degrees of religiosity must be assessed in order to understand their potential strength of influence on all therapeutic and interpersonal change processes.

Atheism, spirituality and New Age beliefs may also have a strong impact on clients' conceptualizations of self and the universe. This occurs in ways congruent with the major values espoused in these particular belief systems (Helle and Eisenstadt, 1985). Furthermore, clients who adhere to more idiosyncratic combinations of values and beliefs as their most meaningful orientations to life, internalize and experience them as privatized or noninstitutionalized religions (Luckmann, 1967).

A clinical strategy of a deliberately constructed exploratory question, together with a probe question follow-up, can assist clients in the articulation of their deepest beliefs—those beliefs which exert the strongest influence on their behavior. Such "fundamental" beliefs necessarily include or imply the basic assumptions that clients make about human nature, together with the range of possibilities for changes in behavior that they expect.

This clinical focus on the articulation of clients' beliefs is predicated upon Weber's hypothesis that values are primary sources of motivation in individual and social action (Weber, 1958). An extension of Weber's thesis is that clients can increase their rationality and autonomy when they choose values which endorse their real interests and enhance their effectiveness in everyday behavior.

Case Studies

The following descriptions illustrate that contrasting values and belief systems have specific consequences for behavior. The summaries below are extracted from life history data collected while defining and redefining a variety of problems affecting the three clients. In most instances clients initiated the first discussions about their religious beliefs, while working on crises of loss, addiction, family violence, divorce, etc.

Deference/Fatalism

Joan, a middle-aged Jewish woman, sees herself as extremely inferior to God. Her understanding and practice of this central belief has disempowering consequences for her everyday life. She is unable to understand herself adequately or to know what she really wants. She is also unaware of her own real interests. She procrastinates in all her decision making, and has several chronic illnesses.

Joan is consistently passive in attitude and action, and she expects and prefers events to happen without her direct involvement. She makes no plans for the future, and she does not see herself as an actor in her life. Her relationships are distant, and she is not able to have satisfactory contact with the God she fears.

Self as Equal to God

Keith is a young white man who was raised in a traditional Roman Catholic setting. In his early adult life he discarded his trained belief in priestly mediation between God and believer. He is now convinced that he has a companionate, personal God who is ever-present in his daily activities. He has personalized his concept of God so much, however, that this God has become an equal and therefore can no longer guide Keith in perplexing situations.

Keith finds it frustrating to live with a concept of God which is dramatically diluted from his original traditional belief in God. He no longer feels able to depend on his concept of God. His diminution of the power and meaning he attributes to God has been accompanied by increased loneliness. Keith's sense of isolation from others seems to result from the fact that he is generally less trusting than before.

Copartner with Powerful God

Tricia is an elderly black Protestant woman who has courageously survived many family crises. In these times of painful change, she thrived by depending on her faith in a powerful and benevolent God. She supports herself effectively through her conviction that God always guides her in beneficial ways. Through her active participation in her partnership with a powerful God, Tricia achieves peace of mind and stability in circumstances which might otherwise be impossible for her to resolve.

Tricia's model of shared responsibility with a powerful God enables her to define purpose and direction in her life. She also enjoys her institutional

affiliation with Protestantism. She transformed her childhood ritualistic worship into meaningful applications of her religious beliefs in prayer and everyday decision making. Her health is good, and her relationships are satisfying.

Principles for Clinical Intervention

Although clinical sociology is defined by a broad range of "vital features" (Glassner and Freedman, 1979), some specific clinical principles can be strengthened or derived from understanding the influence of religious beliefs and values on behavior. Both Weber (1958) and Jung (Hanna, 1967; Progoff, 1985), for example, impressively documented a variety of ways in which religion is a primary source of meaning for many individuals' formulations of beliefs and values. Jung also emphasized the link between religious belief, clinical work, and behavioral outcomes, showing that mature religious belief is a predictor of healthy individual and social functioning (Jung, 1933).

The following principles can be used as orienting premises for specific goals and questions in clinical discussions. Knowledge of religion and belief systems is the basis of these principles.

1. Regardless of clients' particular religious or secular world views, the articulation and definition of their deepest beliefs and values through clinical discussion increases their understanding of themselves, their families, social relationships, society and the universe (Jung, 1933; Pargament et al., 1988).

2. Therapists' understanding of their own religious beliefs and values as well as their understanding of clients' religious beliefs and values increases possibilities for change during clinical problem solving (Commission on Mental Health, 1978). Therapists need not necessarily have the same religious beliefs as clients in order to be trusted or to achieve clinical effectiveness, although clients frequently express strong preferences to work with ministers or therapists with the same religious orientation (Ferrell, 1990). One critical concern, whatever the specific religious beliefs, is that both therapist and client believe that particular changes can take place. Unless this belief is shared, it will not be possible for change to occur (Ashcraft and Scheflen, 1976).

3. Religion defines loci of responsibility for action: does God take care of me, or am I fully responsible for my own decisions (Benson and Spilka, 1973)? Clinicians can accomplish more significant interventions when they know whether their clients are willing to assume direct personal responsibility for the consequences and resolution of their problems.

4. Atheism is an influential belief system, even though it does not have self-evident institutional supports and endorsements. What matters for behavioral analyses and clinical intervention is that atheism, like religious belief systems,

has distinctive assumptions about self, society, and human possibilities. Atheistic belief systems, however, usually markedly emphasize individual and collective responsibility for behavior, life situations, and the well-being of society (Bercovitch, 1975).

5. A particularly significant factor for consideration in clinical interventions is the tenacity with which beliefs are held (Freud, 1949; Rieff, 1966; Fromm, 1967). Dogmatic, rigid beliefs tend to be much more closed, and frequently more difficult for individual adherents and their significant others to deal with, than flexible beliefs which characteristically value human interpretation and spontaneity. To the extent that religious beliefs and ethnicity are intensely interdependent, as in Judaism and some kinds of Roman Catholicism, religion necessarily becomes a very powerful influence on behavior (McGoldrick, Pearce, and Giordano, 1982).

6. When people value a supreme being or power highly and/or believe God to be omnipotent, this belief tends to be inversely correlated with their belief in their own strength and resourcefulness (Durkheim, 1965). In the copartnership model of religious belief, however, this relationship between God and believer is perceived to be in balance. Although God may be experienced as omnipotent, there is a reflective and communicative relationship between God and believer. The "Copartner with Powerful God" is not a pawn of God, or an equal to God, but rather an expression of God through cooperative action.

7. The use of concepts or values from religious traditions can deepen clients' understanding of their growth during therapy (Jung, 1963; Meserve, 1980; Pollner, 1989). Religious beliefs synthesize the microsociological and macrosociological perspectives of human experience, while at the same time defining believers as members of a particular religious community. People can see themselves as integral parts of the whole when traditional religions combine these perspectives in their definitions of reality (Eisenstadt and Helle, 1985).

8. Religion is an important source of values and meaning for both religious and secular goal-directed action (Weber, 1958). Religious beliefs are based on related sets of assumptions and suggest a variety of options for everyday behavior (Berger, 1967, 1977).

9. Knowledge of basic assumptions clients make about themselves and their worlds can be a significant starting point for sociological clinical intervention. After therapists and clients share reflections on these topics, clinicians can initiate discussions, along with a questioning or challenging of any regimented, restrictive, and overly conventional beliefs of clients which seem not in their best interests (Gallup, 1985).

Clinical Strategies

The clinical principles above were used as sources of orientation and discussion strategies in the three selected case studies. The descriptions below pinpoint some of the patterns in behavioral consequences of applications of these principles in exchanges between clinician and client. Although each of the patterns delineated could be functional for clients at different stages of clinical intervention or personal growth, it is the author's impression that the "Copartner with Powerful God" case study has significantly further reaching and lasting benefits than either the "Deference/Fatalism" or "Self as Equal to God" case studies.

Deference/Fatalism

Clinical discussions about how Joan's beliefs influence her personal resourcefulness helped her to acknowledge them as major inhibiting forces. She was able to gradually become more responsible for her beliefs, with the realization that they reflect and generate her own values, behavior and goals.

Continuities in the give and take of clinical discussions made Joan more aware of the choices of belief that she has within the Jewish tradition, as well as in relation to other religions and belief systems. She released some of her previous dogmatism and bigotry, with the result that her attitudes and relationships became more open, flexible and satisfying.

Self as Equal to God

As clinical discussions focused on Keith's willingness to grow and change, he expressed an interest in developing his spirituality. His privatized religion became more integrated with his original Roman Catholic beliefs, and he was able to see himself as newly directed or inspired through his union with God.

Keith's changed beliefs enabled him to clarify and live according to his strong preferences for nonmaterial rather than material values. In this respect, he sacralized his life and made it more meaningful. As he increased his trust in his empowered concept of God, his relationships with family and friends become more personal and more meaningful.

Copartner with Powerful God

Tricia chose to deliberately enhance her faith and relationship with God through increasing the regularity and duration of her prayer and meditation. She

used both her own resourcefulness and the divine guidance she believed in to improve her life situation at all times.

One result of Tricia's sustained effort to strengthen her religious faith was that she balanced her efforts with a positive acceptance of the external circumstances of her life. She increased her life-satisfaction by proving to herself that a rational approach to her values and beliefs increased her resourcefulness, sense of purpose and effectiveness in attaining her goals. Her family relationships were satisfying, and her friendships were supportive and inspiring to her.

Conclusion

Analyses of clinical data, together with reviews of research in sociology of religion and pastoral counseling, generate propositions which can be applied in sociological practice and used in theory construction in clinical sociology. Some of these propositions are:

1. Religions orient and pattern behavior, and serve as important sources of meaning for their adherents (Caplan, 1972).

2. The articulation of religious values and beliefs in clinical discussions can enhance clients' awareness of their priorities and goals in decision making (Berger and Neuhaus, 1977).

3. Religious values and beliefs frequently serve as foundations for identities. Clients may empower themselves through clinical scrutiny as they deliberately identify with the beliefs and values which define both their religious affinities and their real interests most accurately (Mol, 1978; Hammond, 1988).

4. Religious beliefs provide one of the broadest possible contexts for an effective and meaningful examination of an individual's behavior. This perspective and breadth of vision contributes toward a fuller understanding of self than is possible by merely observing everyday situations (Mead, 1934).

5. Examining one's religious beliefs and values serves to clarify distinctions between beliefs that are highly valued and those that are relatively peripheral: clients become able to distinguish between their more sacred and more profane beliefs in this process of refinement.

6. Although some sociology of religion research documents religious influences which inhibit social change (Birnbaum and Lenzer, 1969), clinical data suggest that church/synagogue participation may effectively reduce clients' isolation by encouraging them to participate in meaningful, action-oriented community settings. Active membership in religious congregations can modify clients' attitudes and behavior, frequently improving their overall functioning (Clinebell, 1970).

7. Self-report data suggest that clients' increased participation in sects and denominations—or in atheistic and ethical groups—tends to enhance their life-satisfaction. Participation alone, however, may not necessarily correlate with life-satisfaction (Moberg, 1962; Stark and Glock, 1968).

8. Spirituality is a key concept underlying clients' conceptualizations of a supreme being and their relationships with a supreme being (God, Life, Spirit, the Universe, etc.). Attention to clients' spiritual growth can increase the "en-chantment" factor in our rational-legal society (Weber, 1958). In this respect, everyday beliefs are effectively relinked to what has been described as the religious core of culture (Geertz, 1969), at the same time promoting individual, social, and evolutionary change (Teilhard de Chardin, 1959).

REFERENCES

Alexander, J., B. Giesen, R. Munch, and N. Smelser (eds.)
    1987   The Micro-Macro Link. Berkeley: University of California Press.
Ashcraft, N., and A. E. Scheflen
    1976   People Space: The Making of Human Boundaries. Garden City: Doubleday.
Benson, P., and B. Spilka
    1973   God image as a function of self-esteem and locus of control. Journal for the Scientific Study of Religion 12:297–310.
Bercovitch, S.
    1975   The Puritan Origins of the American Self. New Haven: Yale University Press.
Berger, P. L.
    1967   The Sacred Canopy—Elements of a Sociological Theory of Religion. New York: Doubleday.
    1977   Facing Up to Modernity: Excursions in Society, Politics and Religion. New York: Basic Books.
Berger, P. L., and R. J. Neuhaus
    1977   To Empower People. Washington, D.C.: American Enterprise Institute.
Birnbaum, N., and G. Lenzer (eds.)
    1969   Sociology and Religion. Englewood Cliffs, N.J.: Prentice Hall.
Buber, M.
    1958   I and Thou. New York: Scribner.
Caplan, G.
    1972   Support Systems and Community Mental Health. New York: Behavioral Publications.
Carbine, M. E.
    1980   Religion, psychology, and mental health: the problems of partnership. Journal of Religion and Health 19:40–47.
Caughey, J. L.
    1984   Imaginary Social Worlds. Lincoln, Neb. and London: University of Nebraska Press.
Clark, E. J.
    1990   The development of contemporary clinical sociology. Clinical Sociology Review 8:100–15.

Clinebell, H. J., (ed.)
    1970   *Community Mental Health: The Role of Church and Temple*. Nashville: Abingdon.
Commission on Mental Health
    1978   *Report to the President*. Washington, D.C.: U.S. Government Printing Office.
Durkheim, E.
    1965   *The Elementary Forms of the Religious Life*. New York: Free Press.
Eisenstadt, S. N., and H. J. Helle (eds.)
    1985   *Macrosociological Theory: Perspectives on Sociological Theory*. Beverly Hills, CA:
                Sage.
Ferrell, D.R.
    1990   The religious and moral foundations of pastoral counseling. *Journal of Religion
                and Health* 29:317–27.
Freud, S.
    1949   *The Future of an Illusion*. New York: Liveright.
Fromm, E.
    1967   *Psychoanalysis and Religion*. New York: Bantam.
Gallup, Jr., G.
    1985   Fifty years of Gallup surveys on religion. *The Gallup Report*, No. 236.
Geertz, C.
    1969   Religion as a cultural system. In M. Baton (ed.), *Anthropological Approaches to
                the Study of Religion*. London: Tavistock.
Glassner, B., and J. A. Freedman
    1979   *Clinical Sociology*. New York: Longman.
Hammond, P. E.
    1988   Religion and the persistence of identity. *Journal for the Scientific Study of Religion*
                27:1–11.
Hanna, C. B.
    1967   *The Face of the Deep: The Religious Ideas of C. G. Jung*. Philadelphia: Westminster
                Press.
Helle, H. J., and S. N. Eisenstadt (eds.)
    1985   *Microsociological Theory: Perspectives on Sociological Theory*. Beverly Hills:
                Sage.
James, W.
    1961   *The Varieties of Religious Experience*. New York: Collier.
Jung, C. G.
    1933   *Modern Man in Search of a Soul*. New York: Harcourt, Brace, and World.
    1963   *Memories, Dreams, Reflections*. New York: Vintage Books.
Luckmann, T.
    1967   *The Invisible Religion*. New York: Macmillan.
McGoldrick, M., J. K. Pearce, and J. Giordano
    1982   *Ethnicity and Family Therapy*. New York: Guilford Press.
Mead, G. H.
    1934   *Mind, Self and Society*. Chicago: University of Chicago Press.
Meadow, M. J.
    1980   Wifely submission: psychological/spiritual growth perspectives. *Journal of Religion
                and Health* 19:103–20.
Meserve, H. C.
    1980   Meditation and health. *Journal of Religion and Health* 19:3–6.

Moberg, D. O.
    1962   *The Church as a Social Institution*. Englewood Cliffs, N.J.: Prentice Hall.
Mol, H. (ed.)
    1978   *Identity and Religion*. Beverly Hills: Sage.
Ortony, A., G. L. Clare, and A. Collins
    1988   *The Cognitive Structure of Emotions*. Cambridge: Cambridge University Press.
Paloutzian, R. F., and C. W. Ellison
    1982   Loneliness, spiritual well-being, and the quality of life. In L. A. Peplan and D. Pearl-
              man (eds.), *Loneliness: A Sourcebook of Current Theory, Research and Therapy*.
              New York: Wiley.
Pargament, K. I. et al.
    1988   Religion and the problem-solving process: three styles of coping. *Journal for the
              Scientific Study of Religion* 27:90–104.
Pollner, M.
    1989   Divine relations, social relations, and well-being. *Journal of Health and Social
              Behavior* 30:92–104.
Progoff, I.
    1985   *Jung's Psychology and Its Social Meaning*. New York: Dialogue House.
Rieff, P.
    1966   *The Triumph of the Therapeutic: Uses of Faith After Freud*. New York: Harper and
              Row.
Rosenberg, M., and R. H. Turner (eds.)
    1981   *Social Psychology: Sociological Perspectives*. New York: Basic Books.
Stark, R., and C. Y. Glock
    1968   *American Piety: The Nature of Religious Commitment*. Berkeley: University of Cal-
              ifornia Press.
Teilhard de Chardin, P.
    1959   *The Phenomenon of Man*. New York: Harper and Row.
Tillich, P.
    1957   The relation of religion and health. In S. Doninger (ed.), *Healing: Human and
              Divine*. New York: Association Press.
Weber, M.
    1958   *The Protestant Ethic and the Spirit of Capitalism*. New York: Scribner.

Socio-Legal Definitions of Family

Jean H. Thoresen
Eastern Connecticut State University

ABSTRACT

Recent decisions in family law cases suggest that some courts are ready to broaden
the judicial definition of "family," and to create or accept a definition that extends the
traditional notion of what constitutes a "family." This provides sociologists with an
opportunity to work within or coordinate with the legal system in redefining "family"
to provide a more inclusive concept which courts could then apply.

As "family" evolves in contemporary society, our definitions of family are
expanding to include single-parent families, blended families, gay families, and
various alternative constructions of the social reality of units of individuals who
live together and take on financial and emotional responsibility for each other.
Sociologists have been relatively willing and able to deal with, and in many
instances have helped to create and legitimize, these expanding definitions of
family. However, the definitions sociologists often create, accept, and use may
not be those of the wider society; we are often on top of the wheel as it turns.

The law, as a basically conservative institution, is sometimes slower to rec-
ognize and incorporate new definitions of basic institutions. However, during
the last decade, various courts have been wrestling with expanded definitions
of "family." These definitions are important because courts are often the fi-
nal arbiters of marriage arrangements, parenting arrangements, foster parenting

arrangements, property division upon divorce, custody and visitation arrange-
ments, and many other matters that affect individuals in families.[1]

The purpose of this paper is to examine some ways in which courts have
defined "family," and to explore the role that sociologists can have as consultants
to lawyers and/or courts in educating the legal community to the sociological
reality of what "family" might include. It also makes some suggestions as to
how a new and expanded definition of family could be used to help nonstandard
families gain some of the legal rights normally accorded without question to
more traditional family units.

It is important to note that, while domestic relations law is a creature of
statute in specific jurisdictions, and primarily a matter of state law and, therefore,
state legislative action, the role of the judge is to interpret what legislatures
create. Sociologists who wish to influence the emerging definitions of "family"
under the law may find working with legislatures their most productive arena.
In this paper, however, I am interested in what courts (judges) *do* with the
statutory parameters they are given. Additionally, as will be evident from the
cases cited, some issues that involve defining family are not a matter of domestic
relations (state) law, but of interpretation of things such as zoning regulations
that originate at a local rather than a state level. Thus, the types of official
pronouncements that can affect how people are allowed to form and/or live
in families are highly varied and differ tremendously by jurisdiction. It is not
the intent of this paper to provide a compendium of current domestic relations
statutes jurisdiction by jurisdiction; that can be obtained by perusing appropriate
state law, which is available in most libraries. Rather, I am interested in the social
reality courts construct as they attempt to interpret the meanings of statutes and
ordinances that are involved when courts carry out their function of making
case-by-case determinations of what a "family" is when confronted with a real
case or controversy.

Emerging Case Law

The fairly recent case of *Borough of Glassboro* v. *Vallorosi*[2] provides an
example of what courts have been up to lately in terms of defining "family." A
group of ten male college students was held to constitute a "family" within the
meaning of a restrictive zoning ordinance, by the Supreme Court of New Jersey.
The borough of Glassboro had sought an injunction to prevent the students
from using or occupying a home located in one of the borough's residential
districts under a municipal zoning ordinance limiting residence in the borough's
residential districts to stable and permanent "single housekeeping units" that
constituted either a "traditional family unit" or its "functional equivalent." (With

statutes drafted in such language, it's no wonder sociologists can feel at home in the legal thickets; the legislator's aide who came up with the "functional equivalent" terminology was undoubtedly suffering from a relapse into SOC 100.) The house was owned by one student's parents through a real estate investment partnership. The students, most of whom were sophomores, shared the house's one kitchen, as well as household chores, grocery shopping, and yard work. They maintained a common checking account to pay for food and other household bills. The students all intended to remain tenants as long as they were enrolled at Glassboro State College. The court concluded that these facts reflected a plan by the students to live together for three years under conditions that corresponded substantially to the ordinance's requirement of a "stable and permanent living unit," and thus upheld a lower court's decision.

The recent decision in *Vallorosi* is in accord with a series of decisions. In *Carroll* v. *City of Miami Beach* [3], a district court in Florida decided that a local ordinance's definition of family, based, as in *Vallorosi*, on the concept of a "single housekeeping unit," was broad enough to include a small group of novices who were to live together under the supervision of a Mother Superior in a house owned by the Roman Catholic Diocese of Miami. In *Village of Belle Terre* v. *Borass*,[4] the Supreme Court held that a Long Island ordinance incorporating the "single housekeeping unit" definition of family would allow six students at SUNY Stony Brook to be a "family" for purposes of meeting zoning requirements, thus providing precedent for *Vallorosi* and suggesting that family can indeed be defined according to the concept of a functional equivalent.

Not all recent decisions, however, have accepted the precedent, and specific language can evade the intent signalled by the Court in *Borass*. In 1981, the Supreme Court of Maine held, in *Penobscot Area Housing Development Corp.* v. *City of Brewer*,[5] that a group home population of six mentally retarded adults and rotating pairs of nonresidential supervisory employees who would be in the home in shifts did *not* meet the local zoning ordinance requirements for single-family dwellings, because the local ordinance defined "family" as follows:

> *"Family"* is a single individual doing his own cooking, and living upon the premises as a separate housekeeping unit, or a collective body of persons doing their own cooking and living together upon the premises as a separate housekeeping unit in a domestic relationship based upon birth, marriage, or other domestic bond as distinguished from a group occupying a boarding house, lodging house, club, fraternity or hotel.

While the Maine court arguably could have seen the residents and staff of the group home as the functional equivalent of a family even under that language,

had it chosen to interpret the roles of the individuals with each other as comprising the functional equivalent of a "domestic bond," such a reading could be criticized as judicial activism since there is no mention in the statute of a "functional equivalent" of a domestic bond. Instead, the court chose, reasonably, according to judicial practice, to interpret the language according to its "plain meaning," which did not encompass the idea of functional equivalency. The court said, "the concept of 'domestic bond' implies the existence of a *traditional* [my emphasis] family-like structure of household authority," and that shift rotation of supervisory employees did not meet that criterion, as "[s]uch a structure would include one or more *resident* [my emphasis] authority figures charged with the responsibility of maintaining a separate housekeeping unit and regulating the activity and duties of the other residents." This resident authority figure's role, the court says, would by definition include "stabilizing and coordinating household activity in a way that is consistent with family values and a family style of life."

How can one reconcile *Penobscot* with the principle utilized in *Carroll,* adopted in *Borass,* and followed in *Vallorosi?* Certainly, one could argue that it is merely a matter of statutory interpretation, that is, a parsing of the language specifically adopted by appropriate legislative bodies in creating the ordinances in question. But, as I suggested above, there was also the possibility that the Maine court could have presumed the existence of the idea of functional equivalency when applied to "domestic bond" terminology in the Brewer statute because the idea of using the concept of functional equivalency had already been used in similar zoning restriction cases. Arguably, the Maine court was right; had the city of Brewer intended to recognize the concept of functional equivalency, it could have done so in the language of the statute itself. However, zoning statutes are often of long standing, and nothing prevents courts from introducing modern notions in their interpretations.

A less charitable, but perhaps more sociologically based, suggestion is that nuns and college students are perceived to make better neighbors than are mentally retarded adults and their supervisory personnel. Perhaps there is something different in the supervision of novices and the supervision of mentally retarded adults trying to adapt to independent living conditions.[6] Perhaps what we have here is a judicially approved, and therefore more sophisticated and sanitized, version of "NIMBY" ("Not In My Back Yard").

What should be inducible from these examples is the power of courts to interpret, and therefore create, definitions of "family" as they go about their duty of determining the "true" meaning of the legislatively produced statutes and ordinances under which we live. If reality is a social construction, courts are doing their part.[7]

Given current legal definitions, what is requisite today to be a family? The aforementioned cases suggest some basic elements:

1. Live together, sharing one kitchen.
2. Have a joint checking account or some less formal but shared financial arrangement for handling household expenses.[8]
3. Do the work of the household together.
4. Intend to remain together as a family, at least for a while.

There is one other element that stems essentially from the common law:

5. "Holding oneself out to the community" as a family.

A case that examines this idea with regard to marriage and family is *Ellam* v. *Ellam*.[9] Here is the court's opinion in that case, quoted somewhat extensively as an example of judicial socio-logic (and a slice of daily life):

> Plaintiff instituted suit March 1, 1974, seeking a divorce on the grounds of separation. Defendant's amended counterclaim for divorce charges the plaintiff with desertion.
>
> The parties, who are childless, purchased a home in Elizabeth and commenced moving into their home in June 1972. They were experiencing severe matrimonial difficulties at the time and, according to the plaintiff, he moved to his mother's home in nearby Roselle on or about July 5 and did not thereafter live with defendant.
>
> Although his testimony that the parties thereafter never had sexual relations was not challenged, on cross-examination it developed that the parties nevertheless maintained many aspects of their relationship until May 1973.
>
> On weekday mornings plaintiff's mother would drive him in her car from her home to the corner of his street in Elizabeth. He would walk to his house, let himself in, pet the dog, occasionally kiss his wife "good morning" and, as he put it, "make sure everything was OK." He would then leave the house, take his car out of the garage and proceed to work. When he finished work, or the night classes he was attending, he returned to the matrimonial home. He would play with his dog, converse with defendant and, after she retired, watch television until approximately 12:30 a.m. At that time his mother would arrive to pick him up in her car and take him to her home to sleep, leaving his car in the garage at the marital home. Plaintiff would spend weekends at the marital home doing housecleaning, cutting the lawn and performing similar household chores. He occasionally ate his meals

there, bringing the food with him. On other occasions the parties ate together at plaintiff's mother's home. During this period of time the parties as a couple continued to accept social engagements and once she accompanied him out-of-state to attend a convention lasting several days. They shared a hotel room but did not engage in sexual relations.

Plaintiff, in explaining his continued presence in the matrimonial home, stated that he loved his wife, loved his dog even more, felt obliged to maintain the premises, and, as he stresses, did not want the neighbors to know that he and defendant had separated.

The question presented is whether the foregoing constitutes living "separate and apart in different habitations" within the meaning of N.J.S.A. 2A:34-2(d).

The court construes the New Jersey statute in question by looking at similar cases involving similar and slightly different laws in sister jurisdictions.

In *DeRienzo* v. *DeRienzo*, 119 N.J.Super. 192, 290 A.2d 742 (Ch. Div.1972), it was held that the words "in different habitations" precluded the granting of a divorce where the parties occupied the same house, although plaintiff slept alone in a locked bedroom for which only he had the key. This language in our statute was the basis for the court distinguishing the holding in that case from cases holding to the contrary in jurisdictions which also recognize separation as grounds for divorce. Thus in Delaware, where the statute requires that the parties live "separate and apart without any cohabitation" (13 Del.C, §1522(11)), it was held that a divorce could be granted where the parties occupied the same residence, there being no provision in that statute mandating separate dwellings. *Heckman* v. *Heckman*, 245 A.2d 550 (Del.Sup.Ct.1968). A similar holding was reached under the District of Columbia statute which stated the grounds to be a "voluntary separation from bed and board for five consecutive years without cohabitation" (D.C.Code (1940) §16–403, 49 Stat. 539). *Hawkins* v. *Hawkins*, 89 U.S.App.D.C. 1968). In those jurisdictions the test is not separate roofs, but separate lives. See *Hurd* v. *Hurd*, 86 U.S.App.D.C. 62, 179 F.2d 68 (D.C.Cir.1949). Since every word and clause of our statute should be given effect, and a construction which renders any part superfluous must be avoided, *Hoffman* v. *Hock*, 8 N.J. 397, 86 A.2d 121 (1952), our statute clearly requires both. That is, the parties must occupy "different habitations" and must live "separate and apart."

Here plaintiff arguably resided with his mother, since he slept, took some meals and kept his clothes, all at her home. But with the additional exception of sexual intercourse, the parties continued their relationship substantially the same as prior to his moving. When he was not working or attending classes, basically all of plaintiff's waking hours were spent with defendant.

His plea that their social intercourse was strained and rife with arguments goes to the quality of their association, not its substance. Generally speaking, the policy of our present divorce law is to terminate dead marriages. *Brittner* v. *Brittner,* 124 N.J.Super. 259, 306 A.2d 83 (Ch.Div.1973). But the Legislature, following the recommendation of the Divorce Law Study Commission in requiring the objective proof of the lack of viability in the relationship, has laid down specific criteria in determining what marriages are eligible for dissolution. See Final Report of the Divorce Law Study Commission 73 (1970). Thus, if the parties were not in fact living separate and apart as required by the statute, a mere finding that their relationship was bereft of positive qualities is insufficient.

The court then offers its opinion as to what "social construction of reality" is required for a divorce to be granted, as representing an actual cessation of marriage:

In other jurisdictions, where the parties have continued some degree of relationship after they have ceased sexual cohabitation, divorces have been granted on grounds of separation, provided that it is nevertheless manifest to the community that the parties are in fact living separate lives and are not attempting to induce others to regard them as living together. *Young* v. *Young,* 225 N.C. 340, 34 S.E.2d 154 (Sup.Ct.1945); *Christiansen* v. *Christiansen,* 68 R.I. 438, 28 A.2d 745 (Sup.Ct. 1942); *Hava* v. *Chavigny,* 147 La. 330, 84 So. 892 (Sup.Ct.1920); *Brimson* v. *Brimson,* 227 Ark. 1045, 304 S.W.2d 935 (Sup.Ct.1957). Compare *Adams* v. *Adams,* 89 Idaho 84, 403 P.2d 593 (Sup.Ct.1965). See Annotation, 35 A.L.R.3d 1238.

It has been said that what the law makes a ground for divorce is the living separately and apart of the husband and wife continuously for a certain number of years. This separation implies something more than a discontinuance of sexual relations whether the discontinuance is occasioned by the refusal of the wife to continue them or not. *It implies the living apart for such period in such a manner*

that those in the neighborhood may see that the husband and wife are not living together. [17 Am.Jur., §162 at 232, cited in *Dudley v. Dudley*, 225 N.C. 83, 33 S.E.2d 489 (Sup.Ct.1945); emphasis supplied.]

Where, as here, it is apparent that the associations and dealings of the parties with each other after the alleged separation continue to include a substantial number of the many elements and ties which go into and make up the marital relationship and bind the parties together, it cannot be said that they are living "separate and apart" within the meaning of our divorce statute.

The court therefore holds that although plaintiff and defendant may have been residing in different habitations for more than 18 months, they were not living separate and apart.

A motion to dismiss the complaint at the conclusion of plaintiff's proof is granted.

One wonders whether this gentleman's love for his wife or his dog was more central to his wish to spend a great deal of time in the matrimonial home! What is important to note, however, is that he also desired to keep the neighbors from knowing the real state of matrimonial affairs in his household. And that involves one of the essential elements of marriage and family that any sociologist would identify: that it is a *public* status, often, though not necessarily, attested to by a public rite of passage that announces one's change of status to the collectivity of concerned individuals—those family members, friends, and neighbors with whom one conducts social business.

Roles for Sociologists

As definitions of family change, one thing that may be important to some sociologists is that individuals living in various nontraditional families be able to claim equally legitimated public status. Sociologists can help in this effort by making the act of "coming out," the act of public declaration, less dangerous and frightening for single-parent families, blended families, gay families, and other alternative family units. They can do this by encouraging an environment of tolerance and acceptance for members of nontraditional families and by aiding legal processes that broaden our definitions of family, not just legally, but, as a consequence, socially. In a sense, sociologists can continue to do what they have often done best over the past several decades: remind us of the costs of prejudice and discrimination and the necessity for building a society of inclusion rather than exclusion.

One primary option might involve consulting with legislators, both state and local, on drafting bills and creating statutory language and writing ordinances. Since much work of courts does involve interpretation of statutory language, how a bill is drafted and the definitions of concepts such as "family" which it adopts, are obviously crucial. Sociologists could offer to provide synopses of recent professional literature or statistical analyses to legislators. For instance, many legislators who make it a practice to eulogize the "traditional family" may not realize how few family units actually consist of one employed husband, a wife who does not work outside the home, two kids, and a dog. It might be productive to provide such information for legislators and to provide statistical analyses of their actual constituencies as well. Sociologists, as well as political scientists, have a long history of productive research in these areas.

What else can sociologists do? They can involve themselves in what the courts are doing on such an important matter as constructing the definition of family that will be utilized in official actions. One of the most important roles sociologists can fill is that of the expert witness. The role of the expert witness in legal proceedings is critical because expert witnesses may do what other witnesses are not allowed to do: offer opinions. Once an individual has been qualified in a case as an expert witness, that witness may, on the basis of professional expertise and judgment, offer opinions that can guide the court in its decision. One recent case provides an example of the sociologist at work as an expert witness. In *2–4 Realty Associates* v. *Pittman,* [10] Dr. Peter Stein testified as an expert witness. His qualifications included an academic position and "five books and twenty articles in the area of his expertise, the family in America," and the court stated that "Dr. Stein was an impressive addition to respondent's case."[11] Dr. Stein's testimony enabled a mother and her son, who had created a nonmarital family unit with a man who died from diabetes at the age of 93, to continue to live in a rent-controlled apartment that had been held formally in tenancy only by the man who died. Under the law, only "family members" can continue to inhabit rent-controlled apartments. Dr. Stein offered the opinion that the three individuals constituted a family unit, and, on the basis of his testimony, the court agreed.[12]

Sociologists can make a strong effort to see that Sociology courses are suggested as part of undergraduate curricula defined as "pre-law" or appropriate to pre-legal education. The American Bar Association maintains a Commission on College and University Nonprofessional Legal Studies,[13] which serves as a clearinghouse for syllabus material, runs national conferences,[14] and generally concerns itself with what those who are to become lawyers will learn before they go to law school. Sociologists could become more involved in working with such organizations.

Another possibility would be for sociologists to offer noncredit workshops or even CEU-bearing courses for local lawyers in their vicinity. The Connecticut Bar Association recently offered a CEU-bearing six-week seminar in "Law and Literature" for its members. It is certainly as plausible to conceptualize a seminar in family issues for family law practitioners.[15]

An issue that has recently surfaced, as general recognition dawns that "family" is an emergent concept these days, is the idea of recognizing "domestic partnerships" as the functional equivalents of other, more traditional family structures. The concept of a domestic partnership generally involves two adults who are living together but are "unrelated" in the sense of birth, marriage, or adoption, and who form a household unit. Often these are heterosexuals who simply do not want to get married for various reasons of their own, but partnered gay people also fit this definition. There has been great interest lately, as the cost of health care has exploded, in bringing partners in under the umbrella of health care insurance coverage held by one partner only. Typically, one partner works for an agency or corporation that has good benefits, while the other may be self-employed or work for a small firm without adequate policies. A secondary issue is that coverage for "family" members under the plan of one partner is generally much less expensive than alternative separate private insurance arrangements for the uninsured partner. Legislation of this type has recently been passed for municipal employees in San Francisco, and has been hailed as a great advance by those who advocate recognizing homosexual and lesbian partnerships as "families." Those sociologists who see a definition of family as expansive enough to include such partnerships could provide a service by helping local and state gay task forces to draft and develop rationales for such legislation in their jurisdictions. Domestic partner legislation commonly includes a requirement that partners must agree to be held responsible for each other's incurred financial obligations, which may include medical costs, in order to be covered under a family premium arrangement. Sociologists could support attempts to create legislative recognition of domestic partnership arrangements, based on the fact that such partnerships fit a sociologically based definition of family. Such recognition represents good public policy at a time when leaving people uncovered by health insurance seems a major risk to the general health and well-being of the individual and the society as a whole.

Another area where sociologists may be able to expand the definition of family includes developing clauses in contractual arrangements covering terms and conditions of employment. For example, a contractual provision regarding sick leave, funeral leave, or family care leave often must include a definition of "immediate family." "Husband, wife, father, mother, sister, brother, or child, or any other person who is domiciled in the member's household" is the current

definition for purposes of funeral leave used in at least one faculty contract.[16] This may be particularly relevant for sociologists employed at colleges and universities governed by collective bargaining or less formal faculty/administration negotiations, and who enjoy the chance to construct the definitions of reality that govern their day-to-day lives.[17]

Whatever the personal or political involvement that individual sociologists choose to undertake in regard to legislative or judicial activities involving families, it is clear that the discipline as a whole has at least an opportunity, and perhaps an obligation, to have sociologically refined definitions of family considered by those in policy-making positions. Legislatures and courts are going to go about their business regardless of whether we involve ourselves or not; as the cases presented here have demonstrated, definitional construction of reality proceeds apace. Perhaps our only question is the degree to which we wish to be included in the forces constructing the reality in which we live, and the ways in which we may implement our desire to be included, should that be our conclusion.

NOTES

1. While legislatures are responsible for creating the statutes that define many, if not most, issues in domestic relations law, courts interpret what legislatures create. Courts are therefore among our most important sources of the social constructions of reality, and it is for this reason that court decisions can prove especially interesting to sociologists.

2. NJ SupCt, 1/20/90.

3. 198 So.2d 643 (1967).

4. 415 U.S. 1 (1974).

5. 434 A.2d 14 (1981).

6. Perhaps it is an idiosyncratic notion, but it seems ironic that the mentally retarded adults are trying to become more independent and "adult," and to take their places as functioning members of the larger community, while the novices may be attempting to become less well-functioning members of the larger community, in that they are choosing in a sense to withdraw from it, and to submerge their independent thought and action into the accepted ideas and practices of the total institution which is their order.

7. It is worth noting that courts are not the only official entities engaged in this activity. The U.S. Census bases its count on "housekeeping units" defined by shared cooking facilities, and the recent (1990) form included the idea of "unrelated partners" as a possible definition of household membership.

8. The merging of finances need not be demonstrated by class-based practices such as joint checking accounts. In *2–4 Realty Associates* v. *Pittman* (523 N.Y.S.2d 7 (N.Y.City Civ. Ct. 1987); 137 Misc.2d 898 (1987); 547 N.Y.Supp.2d 515 (Sup. 1989)), the court accepted merged finances evidenced by a pooling of small amounts of money in a cookie jar as the functional equivalent of something like a joint checking account for household expenses. (Personal communication with Dr. Peter Stein, who served as an expert witness in the case. See further discussion of the role of sociologists as expert witness in the following pages.)

9. 132 N.J. Super. 358, 333 A.2d 577 (1975).

10. 523 N.Y.S.2d 7 (N.Y.City Civ. Ct. 1987); 137 Misc. 2d 898; 547 N.Y.S.2d 515 (Sup. 1989)).

11. 523 N.Y.S.2d 9; 137 Misc. 2d 901.

12. The criteria for determining whether an unrelated group of individuals form a family, which Dr. Stein used and which he pointed out are widely agreed on by experts in this area, are: "(1) the longevity of relationships; (2) the level of commitment and support among its members. This support includes both material and emotional support; (3) the sense in which the individuals define themselves as a family unit, using terms such as 'son' and 'father,' for example, and also the way that neighbors and other institutions define them as a family unit; (4) the way in which members of the unit come to rely on each other to provide daily family services; (5) the shared history of the group as evidenced, for example, in the taking, displaying, and preserving of 'family' photos; and (6) the high degree of religious and moral commitment" (523 N.Y.S.2d 9; 137 Misc. 2d 902). Testimony from others provided some of the data on which Dr. Stein's opinion was based. A neighbor testified that the decedent had said about the younger man, "He's my son now." A worker in a local supermarket spoke of going "to see the family." A former employee at the rent-controlled building provided perhaps the central imagery in response to a question on cross-examination as to whether these three people were actually related: "I don't know if they were a family but they acted like one" (523 N.Y.S.2d 8; 137 Misc. 2d 900–01). I would like to thank Dr. Peter Stein for suggesting the use of this case, and discussing it with me, and to thank Lynn Martel of the NYU Law Clinic for providing the citation.

13. c/o American Bar Association, 750 North Lake Shore Drive, Chicago, Illinois 60611 [(302) 988–5725]. Staff Director: John Paul Ryan.

14. One very interesting recent conference, entitled "American Citizenship and the Constitution," was held in Lake Geneva, Wisconsin, May 3–5, 1990, and involved almost a hundred undergraduate faculty in many disciplines, including political science (many faculty from this discipline), history, sociology (with only one faculty participant!), and anthropology.

15. That particular seminar failed for lack of registrants. I do not believe that a seminar on family issues would meet a similar fate.

16. See, e.g., Article 12.1 of the Collective Bargaining Agreement between Connecticut State University American Association of University Professors and the Board of Trustees for Connecticut State University currently in force.

17. The author of this paper has served several different times on the American Association of University Professors negotiating team for the faculty of Connecticut State University, and has found the process open to sociologically derived definitional construction of relevant terms such as "immediate family."

Constructive Conflict Intervention in South Africa: Some Lessons

Hendrik W. van der Merwe
Andries Odendaal
Center for Intergroup Studies, Cape Town, South Africa

ABSTRACT

Historically, South Africa has lacked a culture of trust in negotiation as a conflict accommodation mechanism. During the security clampdown of the P. W. Botha era in the 1980s and subsequent polarization, concepts such as negotiation and mediation were viewed with suspicion in various quarters. However, paradoxically, the labour legislation introduced in 1979 promoted black empowerment, which was to lead to improved prospects of meaningful negotiation and the acceptability of mediation in resolving labour disputes. Concurrently, the township turbulence of the mid–1980s also led to local-level negotiations between blacks and whites. It was found at the national political level that, whilst the time was not ripe for mediation, low-profile facilitation as a more acceptable form of intervention in fact paved the way for the political breakthrough of 1990. Insights developed during this period led to the formulation of a number of principles of communication and included the reconciliation of seemingly contrasting options such as negotiation and coercion, impartiality and concern, and incremental steps and radical goals.

Editor's Introduction:
    This article illustrates the international nature of clinical sociology. Working in a politically troubled country, the authors demonstrate how conflict resolution can be effective at the national political level. In their article, the authors

relate what they have accomplished to a theoretical explication of conflict resolution; this article indeed demonstrates how theory can be put into effective action.

The authors are in a unique position in South Africa. Their success in negotiation is all the more unusual because of the troubled political climate in which the negotiations took place. Because of the unique situation of the authors, they were asked to prepare a brief introduction to the article which places it in the broader context of their work. This introduction follows:

Authors' Introduction:

Hendrik W. van der Merwe, a prominent Quaker and longtime peacemaker and bridge-builder, commands respect from most political camps in South Africa. He pioneered the concept and practice of facilitation of political communication in South Africa at a time when the parties were not ready for formal mediation. He has facilitated and mediated on community, regional, and national levels. He arranged a cease-fire between warring factions in the well-known Crossroads community, mediated between Inkatha and the United Democratic Front in Natal, and in 1984 arranged the first meetings between government supporters and the National Executive Committee of the African National Congress in exile in Lusaka, breaking a twenty-four-year deadlock and significantly influencing public opinion in South Africa.

Van der Merwe, as director of the Centre for Intergroup Studies at the University of Cape Town, and his staff, have over the years also pioneered training in negotiation and mediation in community and political conflict. The secret of their success was their ability to balance their constant nonalignment to any political group, with compassion and concern for the suffering. The formulation of one of the principles of communication mentioned in the article was based on these experiences.

In 1986 and 1988 Van der Merwe organized the First and Second National Conferences on Negotiation and Mediation in Community and Political Conflict, and launched the South African Association for Conflict Intervention (SAACI) and Facilitation and Mediation Services (FMS).

In 1990 a project on the Interpretation and Control of Violence (ICOV) was launched at the request of leaders of the major political parties, and in 1991 Van der Merwe was called in as a mediator between the wide range of community and government parties and groups concerned with the allocation of land to squatters (largely African), who will now be given access to urban resources under the new policies of the country.

Introduction

The end of the Cold War between the superpowers and the decline of ideological conflict has been accompanied by the emergence of new dimensions of conflict: between rich and poor, educated and uneducated, North and South, industrial and developing countries. While the world seems unable to rid itself of conflict and violence, new perspectives on conflict and ways to handle it have brought hope. There is some movement away from confrontation to joint problem-solving, from win-lose to win-win outcomes, from military to political security, and from coercion to cooperation.

Innovative and constructive conflict intervention in apartheid South Africa has contributed toward several breakthroughs and progress toward a negotiated settlement. Some lessons that have been learned from the South African experiences are presented below in three categories: the need for empowerment of the weaker parties, the need for informal facilitation rather than formal mediation, and the reconciliation of seemingly contrasting options.

A History of Distrust

Efforts at facilitating the process of communication between conflicting parties in South Africa have taken place against the background of a history of distrust. It is necessary to refer briefly to this historical context, since the process of constructive conflict intervention is determined by it. In 1988 the Centre for Intergroup Studies (CIS) in Cape Town formulated thirty-three principles of communication that were distilled from local experiences in conflict intervention (CIS, 1988; and Van der Merwe et al., 1990). The central historical experiences and reasoning underlying these principles are discussed.

South African history is not kind toward the concept of negotiated settlements as a method of conflict accommodation. The wrecks of abandoned treaties litter the pages of history books. In 1838 the Afrikaner migrants to the interior, members of the Great Trek, were split down the middle on the very issue of negotiations. One group under Piet Retief wanted to negotiate with Dingane, the Zulu king, for a piece of land to live on in Natal. The other group under Hendrik Potgieter felt there existed no precedent of a treaty made and honoured and were not willing to risk their future on the feeble basis of a signed document. Potgieter split from Retief and trekked into the interior of the Transvaal, prepared to find and defend a living space with the gun. Retief went to meet Dingane. The negotiations succeeded and a treaty was signed, but at the farewell ceremony to Retief and his men, Dingane suddenly ordered them to be seized and executed. His warriors then proceeded to attack the unsuspecting "laagers"

of Retief's followers. To the Afrikaner the verdict of history was clear: Retief was naive; Potgieter was the realist.

Obviously, the Afrikaner were not alone in their suspicion of the trust-worthiness of treaties. The black leaders had as much reason to be profoundly skeptical. The great Sotho king Moshoeshoe, for example, had consistently chosen the way of peaceful negotiations to that of violent conflict. He conducted one session of negotiations after another with the presidents of the Republic of the Orange Free State and with British colonial officials. They signed treaties. But Moshoeshoe discovered to his great disillusionment that these treaties did not have greater power than the hunger for land. Nor were they necessarily tools of justice. After the war in 1856 with the Free State Republic, the boundaries between Lesotho and the Free State were renegotiated, but Moshoeshoe sent back his copy of the treaty and refused to add his mark. "And it was only after two days of wearisome argument, with the old chief vacillating pathetically in the face of continual pressure, that he at last complied" (Sanders, 1975:241).

As the power imbalance between white and black became greater and greater, blacks became increasingly irrelevant as negotiating partners—to the point of their being purposefully ignored in the most important negotiated document of this century: the Constitution of the Union of South Africa of 1910. The few entrenched constitutional privileges that this constitution granted to black South Africans, such as qualified voting rights to blacks in two of the provinces, the Cape and Natal, were removed in 1956 when the National Party enlarged and loaded the Senate as well as the Appeal Court Bench. It was a move that almost succeeded in maintaining legal respectability, but it failed utterly to strengthen respect for the spirit of constitutional procedures. Henceforth, relations between white and black would be governed by benign paternalism at best and stern repression at worst.

It is a paradoxical fact that negotiations between the dominant white and black power blocks became an important item in the political debate again—and indeed a conceivable possibility—during the P. W. Botha era (1978–1989). The government of State President P. W. Botha can best be understood as a transitional government (cf. Bergeron, 1990). Characteristic of such governments, Botha tried to implement reform measures while at the same time keeping firm control of the process. His rule became characterized by the State of Emergency, the prominence of the "securocrats," and the serious repression of political groupings suspected of revolutionary ideals. Yet, on the other hand, he introduced reform, and although very few people outside the National Party were deeply impressed by the extent of his reform measures, they were important because they revealed a fundamental shift in the hearts and minds of the National Party leadership. For example, the institution of the tri-cameral

parliament, though defective and impotent as a constitutional solution, broke the centuries-old mental block in National Party thinking to any idea of power-sharing with blacks. The abolition of influx control effectively shelved the myth that South African cities, and with them the South African economy, belonged to whites only. The abolition of the laws that regulated sexual intercourse and marriage between races symbolised, to a large extent, the defeat of the theological and moral underpinnings of the ideology of racial purity. Not only was the whole structure of apartheid showing cracks in its foundation, but with it the centuries-old assumptions about the power relationship between white and black.

The National Party leadership was beginning to understand that it would have to negotiate with black leaders for a new future. The ambiguity of its position could not be maintained forever. In 1988 Van der Merwe wrote: "While I do not want to play down the intensity and viciousness of the security clampdown in the mid–1980s, I firmly believe that this is not endemic in South African society, but a passing phase. To the extent that the moral base of apartheid has been eroded . . . white (including Afrikaner) leaders lack the moral commitment to such repressive measures as part of a long-term policy. For the moralists and pragmatists in the establishment, such measures can only be justified as control mechanisms during the process of reform" (Van der Merwe 1988:193).

The inevitability of negotiating with the liberation movements, although clear to those with eyes that wanted to see, was not part of the public rhetoric of the P. W. Botha government. The Rubicon had not yet been crossed. The government did accept that negotiations would have to take place, but only with black leaders acceptable to it. The liberation movements, especially the African National Congress (ANC), remained anathema. It was the Botha government that whipped up the frenzy about the "total onslaught." The security clampdown had to be justified, and that was done by demonising movements such as the ANC, the South African Communist Party (SACP), and the United Democratic Front (UDF). It belongs to the paradox of this government that while negotiations became a respectable concept in official rhetoric, the very suggestion of negotiations with the ANC (unless, of course, it surrendered) was considered a treacherous idea.

Concurrently, the mood within resistance movements outside and, especially, inside the country hardened. Those at the receiving end of the security clampdown found less and less reason to be moderate. "Non-collaboration" became the essence of resistance, and the heat was turned on those suspected of collaboration. The homeland leaders experienced this heat, but even more so, those persons who were willing to serve as councillors of the black townships. To be suspected of being a "sell-out" was tantamount to a death sentence in

some circles. The gruesome "necklace" was probably the most potent symbol of this utter disgust with collaboration.

On the whole, the 1980s were not a profitable time for constructive conflict intervention. "Mediation," "peace-making," and "negotiation" were concepts heavily loaded with implications that were politically unacceptable on all sides. The situation was too polarised and the middle ground too weakened for these concepts to have real credibility. Yet, at no other time in South African history were white and black as close to sitting down for meaningful negotiations.

Empowerment Made Negotiation Possible

Principle 7: Where there is gross asymmetry of power between adversaries, a process of empowerment is essential (Van der Merwe et al., 1990).

The power relationship between white and black is at the heart of the matter. Where there is a serious asymmetry of power between adversaries, peace treaties will invariably reinforce the asymmetry. Rather than contributing to the establishment of justice and peace, they will entrench the status quo. A basic principle is that parties equal in power are better able to reach a settlement that is balanced and therefore has the potential to last than when there is an imbalance in power. The political developments of the last two decades have contributed to the potential for peace precisely because they have contributed in various ways to the empowerment of black South Africans.

An important part of the process of empowerment was the success of the liberation movements in influencing and manipulating international opinion. The sanctions campaign was a potent instrument in their hands. However, it was perhaps internal developments that most favoured the process of black empowerment.

The Botha government itself supplied the tool that proved most effective for the empowerment of black people—the legalisation of black trade unions. Since 1979 trade unionism has experienced remarkable growth amongst black workers, not only in terms of numbers and organisation, but also in terms of being an effective political force, a tool of empowerment. The Centre for Intergroup Studies report (CIS, 1988), citing a case study of strike action by the National Union of Mineworkers (NUM) in 1987, observed that their (NUM's) ability ". . . to disrupt an essential basis of the economy has entrenched the union's position as a legitimate and powerful negotiating partner. This was proved despite the lack of the success of the strike in material terms" (CIS, 1988:37). There can be no doubt that the development of trade unionism, despite its negative aspects such as some very ugly cases of scab bashing, has contributed largely to

the empowerment of the weaker party and therefore to improving the possibility of negotiation in South Africa.

An important aspect of this process of empowerment was the creation of institutional structures for the accommodation of conflict in industrial relations which were not only legal, but also enjoyed legitimacy. The conflict resolution structure created and institutionalised through the various labour laws of the P. W. Botha era introduced and gave respectability to the concept of collective bargaining.

Within this structure for the accommodation of conflict, the role of a third party, either as mediator or as arbitrator, was also legally recognised. The increasing demand for mediators in industrial relations and their success in mediating a satisfactory settlement can be seen from the fact that, in a survey of twenty-nine unions for the year 1986, mediation evoked the most favourable response as a procedure for resolving disputes. Eight of the fourteen unions that had resorted to mediation reported satisfaction at the outcome, primarily because the unions maintained their independence and the mediator was seen to be neutral. Two unions were not satisfied with the mediation outcome. Of the fifteen unions which opted for arbitration, and therefore were party to Industrial Court rulings, nine were not satisfied and only two were satisfied with the outcome (CIS, 198:80). The increasing popularity of mediation in industrial disputes in the 1980s can largely be attributed to the growing expertise of IMSSA (Independent Mediation Service of South Africa), which managed to establish itself as a credible mediating body with specialised expertise.

The importance of this development for the creation of a South African culture that trusts the process of mediation and negotiation can hardly be overestimated. At least in the industrial sector (white), management is now learning to treat (black) labour with healthy, if grudging, respect and to be aware of the deep interdependency of both parties. A highlight of this process has been the remarkable agreement in May 1990 between Saccola (the association of big employers) and Cosatu and Nactu (the two main black trade union federations) on recommendations for labour legislation to be proposed to Parliament (*Weekly Mail*, 17 May 1990).

Empowerment at Local Levels

The concept of negotiation also made a breakthrough at another level of society. The great turbulence of 1985–86 when "unrest" spread throughout the country and involved even small rural townships—was explained in official circles as a calculated strategy by revolutionary forces to make townships ungovernable. Swilling (1989), on the basis of case studies collected from thirty

townships, has argued that ungovernability was not the primary strategy, but that, in a paradoxical way, some of the most constructive and meaningful attempts at negotiations in the history of the country took place at the local level during this time. What happened, according to Swilling, was that local bodies—an "intense network of trade unions, community organisations, student and scholar movements and political organisations" functioning under the umbrella of the United Democratic Front (UDF)—took up issues of local concern and organised protest campaigns such as stay-aways, consumer boycotts, and strikes. This led to the development of a "dual power" situation, with the community organisations functioning as alternative political structures. Preconditions for the first meaningful negotiations with representatives of the establishment at local levels were thereby created. White business concerns, especially, showed themselves ready to negotiate with community leaders, but in some cases government officials were also involved. The short-term benefits flowing from some of the negotiations strengthened the popular support of the community organisations and had the important side-effect of weakening the noncollaborationist position. This promising development was frustrated when the State of Emergency was introduced.

Friedman (1989) has expressed criticism of Swilling's analysis, saying that he has idealised the picture and ignored some of the complexities of the situation. If the government mistook what was happening as an attempt at ungovernability, it was because some of the people in the "struggle" laboured under the same misunderstanding! Friedman, however, is in agreement with Swilling's basic thesis that a real potential for meaningful negotiations at the local level did exist at the time because of the empowerment process amongst black communities. It was an option successfully exploited by some, even though, according to Friedman, there was not the same enthusiasm for this option amongst all concerned.

There were signs, therefore (although at times it took the eyes of faith to detect these signs), of developments within South Africa at both the national and local levels which were favourable to negotiation as a strategy for conflict accommodation.

Third Party Intervention: Mediation

Principle 16: Where negotiation between adversaries is not possible because of rigid stances, inadequate communication or structural obstacles, mediation is required (Van der Merwe et al., 1990).

Whereas negotiations became possible at some levels of society, the tense, polarised climate at the national political level meant that the major parties were

not yet ready to enter into negotiations. It was a situation that called for third party intervention.

It is necessary to distinguish between neutral and partisan intervention. Whereas partisan intervention has the aim of favouring a specific position or party, the purpose of neutral intervention by a third party is usually to mediate between conflicting parties, to improve communication and to promote a negotiated settlement. Mediation, therefore, refers to intervention in a dispute or conflict by an acceptable, impartial, and neutral third party (Van der Merwe, 1989:88).

An important example of an attempt at mediating in the South African political conflict was the high-profile attempt by the Eminent Persons Group, representing the British Commonwealth, in 1986. Many observers described this mission as a failure, but such an evaluation misses the contribution that it made by happening at all, by formulating common ground between the parties, and by promoting the concept of third party intervention and the idea of a negotiated settlement.

The experience of the Eminent Persons Group showed, inter alia, that the time for formal negotiation or even mediation between the parties was not ripe. This left the option of informal mediation of facilitation.

Facilitation of Communication

Principle 17: Where formal mediation is not acceptable, informal mediation may be successful (Van der Merwe et al., 1990).

Facilitation can be distinguished as a specific option on the continuum of conflict intervention possibilities. It is primarily concerned with the facilitation of communication between conflicting parties. Whereas in mediation there is a specific commitment to the outcome of the process (a settlement), facilitators are committed to communication as an end in itself. The facilitator is, in an almost technical way, concerned with ensuring that the relevant parties gain accurate information, regardless of the use they make of it. "For the facilitator, facilitation of communication is an end in itself, in much the same way as one can pursue knowledge for the sake of knowledge or atomic power for the sake of power. . . . For these reasons a facilitator may, in situations of extreme polarisation and intense suspicion, be more acceptable to conflicting parties than a mediator. The neutral and almost technical services of the facilitator would appear to be more functional than the assistance of a mediator, who is morally committed to peacemaking" (Van der Merwe, 1989:95).

A breakthrough in facilitating communication between the establishment in South Africa and the ANC came in 1984. After establishing contact with the

Mandela family and the ANC in exile, Van der Merwe (an "honest Quaker bro-
ker," as the ANC referred to him), was asked by the ANC to introduce them
to members of the government. In December he introduced Dr. Piet Muller,
assistant editor of *Beeld,* the largest pro-government Afrikaans daily paper, to
members of the ANC executive committee in Lusaka. Dr. Muller subsequently
wrote two articles in his paper in which he described common ground between
the National Party and the ANC and, in an editorial, *Beeld* called on the gov-
ernment to talk to the ANC. This was the first contact of its kind in twenty-four
years and, because of the positive tone of the articles, it broke the deadlock. The
readers of the Afrikaans press could, for the first time, read something about the
ANC which was not a description of the evil of the organisation. In a subsequent
interview on the prestigious Afrikaans programme, "Om die Waarheid Te Sê,"
Van der Merwe described the ANC leaders as reasonable, well-meaning South
Africans who had only resorted to the armed struggle because all legal avenues
were closed to them.

     A number of encounters between various internal South African groupings
and the ANC in exile subsequently took place. Giliomee (1990) has calculated
that approximately fifty encounters took place between internal groupings and
the ANC during the 1980s. It was the highly symbolic trip of prominent Afrikan-
ers to Dakar, organised by the Institute for Democratic Alternatives for South
Africa (IDASA), that especially captured the public imagination and contributed
largely to breaking down some of the stereotypes that existed concerning the
ANC. Without doubt, these "safaris" to the ANC and numerous conferences
organised by IDASA made a large contribution to educating the (white) public
and providing more reliable information concerning the ANC, and vice versa.
Thus, the facilitation of communication contributed in preparing the way for the
dramatic breakthrough of 1990.

Contrasting Options

     Would-be mediators or facilitators in South Africa not only had to face the
absence of a culture of trust in negotiation as conflict resolution mechanism
and the gross asymmetry in power between the conflicting parties, but they
also had to face the fact that the situation evoked serious questions concerning
the morality of intervention or attempts at "peace-making." Strong perceptions
existed that the black people were oppressed and that the prevailing system
was deeply unjust. This led to the moral pull toward activist programs that
favoured the process of empowerment and a concomitant suspicion that any-
thing else would compromise the struggle for liberation. A neutral mediating
position shared the brunt of this suspicion. One of the most important lessons

learned during this time, therefore, was that intervention options should not be restricted to one type only, but that several contrasting options were available, ranging from the activist or partisan role to that of the mediator or facilitator. "While it is readily admitted that such options could result in ambivalence (or even schizophrenia), the . . . [thesis] is that, given the necessary sensitivity and initiative on the part of an intermediary, creative and constructive intervention is possible" (Van der Merwe, 1988). It is important to see the contrasting options not as contradictions, but as complementary options on a continuum of possible conflict intervention strategies. The following three examples may illustrate the point.

   (1) *Principle 4: Coercion and negotiation are complementary aspects of the process of communication between adversaries* (Van der Merwe et al., 1990). Parties in conflict are obviously in communication with each other. If it were possible to ignore each other, there would be no conflict. This communication can take the form of coercion, with war or terrorism as extreme examples at one end of the continuum (speaking, as it were, with bombs and guns), and cooperative behaviour such as rational negotiations on the other end of the spectrum. "Wars may continue while peace negotiations are in progress, each side attempting to add military pressure to the force of diplomacy" (Curle in Van der Merwe, 1989:xiv). While coercion (including violence) and cooperation (including negotiation) stand in a relationship of tension toward each other, they are not mutually exclusive (Van der Merwe and Williams, 1987).

   In South Africa there was a clear need for coercive measures aimed at empowering the weaker party and at changing a fundamentally unjust system. In the heat of the polarised debate, the option of negotiation was often seen as contradicting the "struggle," as being an opposing strategy to that of coercion. This, however, is a misconception. Negotiation should be seen as complementing pressure in the communication process between conflicting parties. By improving the quality of communication and understanding, negotiation will ensure more rational and effective pressures and more orderly change, thus reducing the likelihood of destructive violence. In other words, pressure for change was not lessened by facilitating communication between the political parties or by the negotiations that happened at the community and industrial levels. Rather, it became possible to apply these pressures and to respond to them in a more rational way.

   Current negotiations between the government and the ANC should be seen within this context. The ANC relies heavily on the sanctions campaign of the international community, various forms of pressure within the country, and its own armed struggle as forms or, rather, symbols of coercion of its adversary. Some

of these pressures have made significant contributions to getting the government to the negotiating table. But the negotiating table is not the end goal. It is only a means toward the goal of justice and peace.

For that reason, certain sanctions will continue to play a role in exerting pressure on conflicting parties in South Africa. Sanctions, in order to complement negotiations, must, however, be constructive and conditional, and not like the conventional, emotional, vindictive, anti-apartheid campaign targeted against only one party. They must be rational, based on a cost-benefit analysis (Van der Merwe, 1989:84–86). And, of course, sanctions should be aimed at all parties in the negotiating process; at the ANC to guard against authoritarian and one-party rule and the violation of human rights, at the Pan Africanist Congress (PAC) and the Conservative Party to persuade them to enter into negotiations, and at others.

This understanding of the complementarity of coercion and negotiation applies also to the theological and moral debate concerning the relationship between peace and justice. For decades the quest was for justice, but the popular slogan had it that no peace was possible before justice has been established, thereby making justice an absolute precondition of peace. This purist view ignored the dialectic dynamic of the interplay of peace and justice on each other. Peace contributes to justice as justice contributes to peace. It follows that the means used to pursue these goals of justice and peace, namely empowerment and conciliation, respectively, are complementary. The fact that, in a given situation, greater emphasis needs to be placed on the quest for justice can in no way cancel the remaining relevance of striving for peace. South Africa needs its prophets (of justice) as well as its priests (of reconciliation). Admittedly, the responsibilities, tasks, and styles of peacemakers and prophets are different and can cause severe tensions within any one individual or between individuals and groups (Van der Merwe, 1989:116).

(2) Principle 15: An incremental approach to change can be reconciled with radical goals of fundamental change (Van der Merwe et al., 1990).

The violence that occurred in South Africa involved, in the great majority of cases, people who did not differ on the end goal of the political process—the abolition of apartheid—but who differed on means and strategies. This fact can partly be explained by the natural tendency to regard those who work toward goals different from your own as enemies, and to regard those who have the same goal but employ different strategies as traitors. Traitors are perceived to threaten the hegemony of your group and therefore also its eventual success. This gives rise to intense animosity that may surpass the hatred felt toward the common enemy. In South Africa the violence between Inkatha and the UDF in Natal, for example, can be seen in this light. The difference in strategy in

this case can largely be explained by the willingness to work in a gradual way toward change (Inkatha) and a radical strategy of noncollaboration (UDF).

The experience of the trade unions proved that the acceptance of short-term gains need not conflict with their pursuit of long-term goals. The unions had to face the issue of whether to register in terms of the relevant legislation, thereby "collaborating" within a government system. Their experience, after registering, was that the organisational and legal space now offered to them provided the platform for challenging the structure itself. The bargaining reputation thus established in the short term consolidated strength for the attainment of long-term goals (CIS, 1988:56). The community groups, too, realised that they need not compromise fundamental goals and principles by participating in some aspects of the existing system. As these organisations gained in public support (partly a result of successful short-term benefits), the danger of being co-opted by the government was reduced.

(3) Principles 22–24: Impartiality is compatible with compassion and concern (Van der Merwe et al., 1990).

One of the most important qualities of a mediator or a facilitator is impartiality. Usually intermediaries can be drawn from outside parties which have little or no interest in the outcome of the dispute. It became impossible to be neutral about the South African conflict, however. This conflict was internationalised to an extraordinary degree, owing, inter alia, to the universal dimensions of the problem. The South African problem is about racism, colonialism, and the exploitation of the poor. South Africa reminds the whole world of a time when white superiority over other races was an obvious presupposition, and no one enjoys this memory. Neutrality toward South Africa came to mean indifference toward exploitative racism.

If it was almost impossible to find neutral intermediaries from outside, it was obviously more difficult inside the country. "Farewell to Innocence," the title of Allan Boesak's doctoral dissertation (1977), implied that the time for presumed clean hands was past. Each person in South Africa had to make a choice. Either you were supporting apartheid, if not actively, then through your silence, or you were actively against it. Neutrality was as immoral as the support of apartheid.

Anyone intent on playing a mediating role in the South African situation, therefore, had to face a very difficult moral decision. Experience has demonstrated, however, that impartiality is not incompatible with concern.

After a particularly violent interaction between the government and the ANC in 1982–1983, involving bomb explosions inside the country and S.A. Defence Force raids on ANC quarters in Lesotho and Mozambique, Van der Merwe issued a statement expressing disapproval of violence on both sides, sympathy

with victims on both sides, belief in elements of goodwill on both sides, and the intention to make financial contributions to victims on both sides. In spite of the fact that this statement was attacked from both sides of the conflict, it played a major role in the development of the relationship of trust between him and the ANC and between him and the establishment in subsequent years. This enabled his role as facilitator to develop.

Impartiality does not mean indifference toward serious moral issues. On the contrary, impartial concern may reflect a specific dimension of morality.

Given the fact that the majority of the South African population is Christian, the debate on the morality of impartiality took place in Christian theological terms. The well-known *Kairos Document* categorised the dominant Christian reactions to the political situation into three types: namely, those supporting the status quo theologically; those who emphasized reconciliation (which Kairos rejected as a dishonest attempt not to rock the boat—no reconciliation with sin is possible); and those who took up the prophetic option of denouncing the sin of apartheid in word and deed (Kairos Theologians, 1985). Whereas there is obvious validity in what Kairos said, it was too one-dimensional. The "preferential portion for the poor" need not imply as a necessary complement the demonising of the rich and powerful. The Religious Society of Friends (Quakers), for example, have a consistent tradition of "answering that of God in every person." This approach enables them to empathize with all parties to a conflict. They have established world-wide respect as mediators. In fact, the Christian gospel has at its heart the concept of *agape*. This Greek word for love is distinguished from its synonyms in Greek by the fact that it describes a quality of love that does not depend on the merit of the object of that love. In other words, an approach that refuses to relate to "sinners" because of a selective concern for the "sinned-against" may have strategic value, but cannot claim to have sole rights to justifiable morality.

A distinction is therefore necessary between a concern for the suffering and predicaments of human beings and preferential support for any one party in the conflict. "Genuine concern can be expressed for a group without supporting any of its particular stands, goals, policies, or methods" (Van der Merwe, 1989:91). Selective concern based on partisan politics is deplorable. Selective concern based on humanitarian feelings is understandable, but it remains important for mediators and facilitators to maintain their impartiality in order to function successfully.

Conclusion

In his foreword to Van der Merwe's book (1989:xiv), Adam Curle describes the "hideously difficult position" of a mediator. "The protagonists with whom

they deal try to make use of them for their own ends. They also mistrust them; for how could they really be their friends if, as they claim, they are also the friends of their enemies? . . . But the position of someone working in his or her own country is immeasurably more complex. They are *part of the situation they are attempting to alter.* How can they balance the necessary impartiality with the equally necessary partisanship of change? How can [they] avoid the inner tensions and contradictions of what the psychoanalysts call 'doubled (and in this case, sometimes treble, I suspect) role trouble'?"

The lessons learned over the past two decades have proved, however, that the option for neutral third party intervention is not only possible, but also effective. It is an option, alongside other options, that can be pursued with credibility and integrity. The option for constructive conflict intervention is not a "sell-out" position to be reserved for the faint-hearted. It is an option for those who love peace as much as they love justice.

REFERENCES

Bergeron, J. F.
    1990   Reform of apartheid and authoritarian rule: Some guidelines towards an understanding of the government of P. W. Botha (1978–89). Unpublished research paper, Centre for Intergroup Studies, Cape Town.
Boesak, A. A.
    1977   *Farewell to Innocence: A Social-Ethical Study of Black Theology and Black Power.* Johannesburg: Ravan Press.
Centre for Intergroup Studies
    1988   *Principles of Communication in South Africa.* Report submitted to the Urban Foundation.
Friedman, Steven
    1989   Idealised picture of township organisation. *Die Suid-Afrikaan* 22.
Giliomee, Herman
    1990   ANC-NP alliance in view? *Cape Times* (22 February):6.
Kairos Theologians
    1985   *The Kairos Document.* Braamfontein: Kairos Theologians.
Sanders, Peter
    1975   *Moshoeshoe, Chief of the Sotho.* Cape Town: David Philip.
Swilling, Mark
    1989   "Onregeerbaarheid" of Onderhandeling. Die lesse van '85-'86. *Die Suid-Afrikaan* 18.
Van der Merwe, Hendrik W.
    1988   South African initiatives: Contrasting options in the mediation process. Pp. 180–94 in C. R. Mitchell and K. Webb (eds.), *New Approaches to International Mediation.* Westport: Greenwood.
    1989   *Pursuing Justice and Peace in South Africa.* London: Routledge.

Van der Merwe, Hendrik W., and Sue Williams
    1987   Pressure and cooperation as complementary aspects of the process of communica-
              tion between conflicting parties in South Africa. *Paradigma* 1(1):8–13.
Van der Merwe, Hendrik W., Johann Maree, André Zaaiman, Cathy Philip, and A. D. Muller
    1990   Principles of communication between adversaries in South Africa. In John W.
              Burton and Frank Dukes (eds.), *Conflict: Readings in Management and Resolution.*
              New York: St. Martin's Press.
Weekly Mail
    11–17 May 1990

Combining Sociology with Epidemiology: Community-Oriented Primary Care in a Rural Mountain County

Thomas Plaut
Suzanne Landis
June Trevor

ABSTRACT

Community-Oriented Primary Care (COPC) focuses attention on the community as "patient" and involves its residents in a process of discernment of health needs and consequent action. COPC's emphasis on community involvement provides an opportunity for the sociologist to create the tools for resident participation in health needs assessment and subsequent interventions. This paper describes sociology's role in a rural Appalachian county COPC program funded by the W. K. Kellogg Foundation. Some 41 focus group interviews were employed to reach more than 416 residents. Interview results were combined with epidemiological and census data and fed back to a 27-member Community Advisory Board, where nominal group techniques were used to develop a prioritized list of needs and consequent interventions. Two interventions began in the fall of 1990. One is a dental sealant program for schoolchildren. The second involves training "lay community advisors" to work with parents of newborn children in efforts to improve infant health and parenting.

In July 1989, a four-year Community-Oriented Primary Care (COPC) project was initiated by a multiple-agency consortium in Madison County, a rural mountain county with limited economic resources in western, Appalachian North Carolina. COPC focuses on the community as "patient" and involves its residents in a process of discernment of health needs and consequent action. As part of a "community assessment," which included a review of census and epidemiological data, a research team made up of an epidemiologist (Landis), a community organizer (Trevor) and a sociologist (Plaut), conducted forty-one focus group interviews between August and December. This paper describes

the role focus groups played in the community assessment and in the overall development of the project.

The Theory of Community-Oriented Primary Care

COPC takes a geographic area—in this case Madison County—and treats it as a physician would treat an individual patient. The entire health delivery system is analogous to the physician in a one-on-one encounter. The community's perception of health needs is similar to the patient's chief complaint to the doctor. Epidemiological analysis of morbidity and mortality plays the role of a physical examination and patient history in defining medically related problems and needs. Community action and interventions parallel patient treatment. Monitoring the impacts of the interventions parallels individual diagnostic testing. Continuous modification and development of interventions is similar to the individual patient's receiving adjusted care during follow-up visits to the physician (see Table 1).

Table 1
COPC Compared to Clinical Care

COPC	CLINICAL CARE
1. A community/defined population	The patient
2. A health delivery system	Doctor or other practitioner
3. Community's perceived needs	Patient's chief complaint
4. Epidemiological research	Patient physical exam and laboratory tests
5. Identifying and prioritizing community health problems	The diagnosis
6. Interventions	The treatment plan
7. Monitoring of interventions	Follow-up history, physical, and diagnostic tests
8. Modification of interventions	Modification of treatment plan

Source: Henry Taylor and Carl Taylor, 1989

The community is at the core of COPC theory and practice. The community —in dialogue with medical and human services professionals—consequently plays a major role in defining needs and determining interventions. If the professionals take too strong a leadership role, they lose the community's support

and the interventions fail or their impact is greatly reduced (Maguire, 1987; Cancian and Armstead, 1990).

COPC was developed by two physicians, Sidney and Emily Kark, working among the Zulu in South Africa in the 1940s (Overall and Williamson, 1987; Trostle, 1986). Their methodology of community care involved four stages:

1. Identifying the community—meaning the total population, not just users of the medical center. Study of the community included an analysis of its social structure and patterns of relationships, traditional healing methods, economy and economic need, nutrition, etc.
2. Identifying community health problems
3. Involving the community in determining priorities in health needs
4. Constant monitoring of interventions to evaluate effectiveness and make modifications on a continuing basis.

In South Africa, the Karks and COPC ran afoul of apartheid in 1957; white physicians were no longer allowed to treat black patients. Sidney Kark was invited to chair the Department of Epidemiology at the University of North Carolina at Chapel Hill, joining former Polela colleague John Cassel, who had come there in 1954 on a Rockefeller Foundation grant (Trostle, 1986:67). The idea of COPC in the United States spread from UNC to Duke University, UCLA and Harvard . . . and eventually to Madison County.

Located along North Carolina's mountainous border with Tennessee, Madison County consists of an area of 456 square miles, with a population of 17,162 living in some 5,500 households. Madison is part of the 397-county federally designated Appalachian Region. The term "Appalachian" implies a cultural tradition which emphasizes family, community and self-sufficiency, tied paradoxically to a century of economic disintegration and crisis (Eller, 1982). Forty percent of its elderly live below the poverty line as do more than 38 percent of its 4,161 children under the age of eighteen (N.C. Department of Environment, Health and Natural Resources, 1988).

The population is relatively homogeneous. It is virtually all (98.9%) white and rural (79%). Almost half of its labor force is employed in agriculture. Of its 17,500 people, some 3,600 live in small towns: 800 in the county seat of Marshall, 700 in a turn-of-century resort town called Hot Springs (where the warm spring-fed baths are currently being repaired for use after many years of abandonment), and 2,100 in the college town of Mars Hill.

Historically, Madison has been a county of family farms where burley tobacco has been the major cash crop. But in the 1980s, major tobacco companies turned to cheaper overseas suppliers, while demand for tobacco also

dropped. The number of farms in the county decreased 11.8 percent between 1982 and 1987. Of the remaining 1,305 farms, 1,142 (87.5%) had incomes less than $10,000, indicating that, for most people, farming has become a second source of revenue behind "public work" in commerce, industry and government. Whatever the source, per capita income is low at $9,261 in 1987, 59.8 percent of the national $15,484 average. Madison ranks 98th in per capita income among North Carolina's 100 counties (N.C. Bureau of Economic Analysis, 1989). The county's isolated and mountainous terrain has seriously limited the development of a manufacturing industry and it "took a pummeling in 1986 when a shoe factory closed, with 435 jobs lost—nearly 40 percent of the county's total" (McCarthy, 1990).

The consequent lack of economic opportunity has led to the flight of the working-age population leaving a higher percentage (14.4%) of people over sixty-five (the state average is 10.2%). Of the 2,426 elderly registered in the 1980 Census, 40.8 percent were living below the poverty level.

Isolation and distance from services and employment have a significant impact on the lives and opportunities of residents. When the county's eight townships were ranked on a scale of 1 (close to jobs, services and the high school and college) to 4 (most distant from them), it appears that the more remote the township, the more likely its residents are to have an income below the poverty level ($r^2 = .797$) (N.C. State Data Center, 1980). Problems of isolation and the lack of transportation—to schools, doctors, etc.—were mentioned repeatedly in group interviews that reached more than 400 county residents in the fall of 1989.

The county death rate in 1986 was 9.04, compared to a state rate of 8.62. Heart disease was the leading cause of death and had a rate of 317 per 100,000; the state rate was 306. Similar high county mortality rates are seen for cancer, cerebrovascular disease, diabetes mellitus, and pulmonary disease (N.C. Division of Statistics, 1989). However, since these rates are not 25 percent above or below state averages and are based on very small numbers, the county rates are not considered significantly different from those of the state. On the other hand, data on dental caries (27% to 63% of K-8 students in the county's eight schools) indicate a serious need for dental hygiene and preventive care.

The county's annual child abuse rate, as reported by the North Carolina Department of Human Resources, Division of Social Services, for the years 1985–1988, proved to be a cause for concern. The abuse report rate per 1000 for the entire state averaged 5.7 to 5.9. The range in Madison County was 8 to 10. Neighboring counties Yancey and Mitchell, with similar socioeconomic and demograhpic characteristics, had rates of 3 per 1000. Madison's substantiated abuse rate was also higher. Research staff discussions with teachers, social

workers and scout leaders confirmed these findings (see focus group comments on children).

In sum, Madison County is a rural county where cultural tradition emphasizes family and community, but it has a troubled economy and a number of people stressed by poverty and limited economic opportunity. It shares the contradictory Appalachian heritage of environmental beauty and destruction, and of struggles for self sufficiency, independence, and dignity in the face of a disintegrating economy.

Making Changes: Community Development and Health Care in Madison

People have been attracted to Madison County by both its needs and beauty. In the late 1960s, two nurses traveling through the Hot Springs area conducting a "health fair" screening program were sufficiently impressed to return in 1971 to look into the possibility of organizing a home nursing service. They established a small clinic in Hot Springs with the assistance of a doctor located some 45 miles away in the city of Asheville. The nurses obtained federal funds the following year, hired more staff and established two other small clinics in the nearby communities of Walnut and Laurel. Today, the Hot Springs Health Program has four medical centers staffed by six physicians, two family nurse practitioners, a dentist, a pharmacist, and ten nurses. It provides a range of hospice, home health nursing, clinical, dental, and pharmaceutical services. It also provides home chore services for the developmentally disabled, and physician and midlevel support for the county health department, the college infirmary, and two nursing homes. Its physicians also serve as county medical examiners. Its staff logs some 36,000 patient encounters annually.

The county's ability to organize its limited resources has been demonstrated not only in the building of four medical centers, but in the creation of a Habitat for Humanity housing program, a hospice, counseling and crisis services for battered women and victims of sexual assault, volunteer fire departments, community development clubs and a privately funded service called "Neighbors in Need," which provides funds, food and other assistance to people caught by emergencies. The networking of these organizations with public services (schools, mental health centers, emergency medical services, the county health department and the Department of Social Services) was a primary reason cited by the W. K. Kellogg Foundation for its funding of the four-year COPC project, which began in July 1989.

Bringing Community-Oriented Primary Care to Madison County

The Idea of Community

Community-Oriented Primary Care begins with the community assessment, a task co-directed in the Madison County project by an epidemiologist and a sociologist who had worked in the county for over a decade. The first goal of the assessment was to understand what people in Madison County meant by the word "community." The county's three postmasters were asked to map communities within their zip code areas. Their maps were then validated and refined by other informants from various parts of the county. Communities turned out to be small units based on traditional kinship ties and land holdings. Some seventy-two units were identified, along with 350 "community helpers" (defined as people whom residents of a specific community would call if they needed advice or assistance).

The discovery of seventy-two subjectively defined communities emphasized that, for many residents, the county is not a single, viable entity as much as the traditional, kinship-based neighborhood of the mountain "cove" (Eller, 1982). The strong identification with local "place" and relationships would limit COPC community-based interventions: specific communities and their own trusted networks and organizations would become the basis for "community action." (This insight helped shape the development of the Laurel community "Parent Team" intervention described below.)

Means of Assessment: The Focus Group

The Executive Board for the COPC Project includes representatives of the Mountain Area Health Education Foundation (located in Asheville and related to the Schools of Medicine and Public Health at the University of North Carolina at Chapel Hill), and county residents associated with the Hot Springs Health Program and Mars Hill College. One of the county residents insisted that surveys *not* be employed in the community assessment. "These people have been surveyed to death," he said. "They're tired of being asked if they're poor."

The community assessment team consequently turned to focus group methodology. Focus groups had previously been employed to evaluate Hot Springs Health Program staff relationships (Plaut, 1988). The COPC project required the adaptation of focus group methodology to local conditions and project goals. The fragmentation of the county by its mountainous geography, its seventy-two communities and its various agencies and schools required more than the recommended three to eight groups. The project goal of community-based change

required that as many viable county groups as possible be included. Conse-
quently, forty-one focus groups were set up to reach service providers: doctors,
home health nurses, mental health therapists, school teachers, emergency med-
ical technicians, extension agents, senior meal site operators, child day care
providers, etc., and all viable community groups, including volunteer fire de-
partments, community development clubs, scout leaders, and Parent-Teacher
Associations.

The focus groups were conducted between August and December 1989,
involving 416 county residents. The setting for each group was its own "turf,"
be it a school, a fire department garage, church or an office.

Using Focus Groups In The Madison County COPC Project

Ideally, focus groups are made up of seven to ten participants having similar
social locations, values and worldviews. The discussion is led by a facilitator,
who has a specific agenda or series of questions. Sessions last from one to
three hours and are often audiotaped for later content analysis (Basch, 1987;
Krueger, 1988; Morgan, 1988, 1990). Given the technical difficulties presented
by some interview sites in Madison County and the discomfort created by the
initial uncertainty of some groups about the nature of the project, audiotaping
was ruled out and a two-person interview team was used. It usually consisted
of a man and a woman who alternated the roles of facilitating and note taking,
depending on the nature of the group. (For example, it proved more effective
to have a male facilitating a discussion in a working class, virtually all-male
volunteer fire department.) The questions presented to each of the forty-one
groups were:

1. What personal health problems or physical complaints appear to be most
   commonly mentioned by people in the community?
2. What barriers to health care or medically related issues do people in the
   community talk about?
3. What, in this group's opinion, are the serious health problems in the
   county? What are the causes of these serious health problems? What in
   this group's opinion are the serious barriers to health care?
4. What needs to be done to handle these problems?
5. Do you feel that there is any group of the population not receiving
   adequate medical care? Why not?
6. Who do people call in this community when they need help or advice?
   (This question was asked only in community groups, such as volunteer
   fire departments and community development clubs.)

Focus group participants were given a copy of the questions to provide an opportunity for individual written responses. This proved significant in cases where a respondent noted either an issue passed over in the discussion or something he or she felt was too sensitive to be mentioned in the group.

Each focus group session was written up in narrative form by both facilitators within twenty-four hours. These accounts were then compared and consolidated into a single report. The reports were subjected to a content analysis to transform the qualitative data into a quantified form. Some 230 diseases, causes of pathology, perceived barriers to health care, etc., were coded on a scale of 0 to 2, with "0" meaning no mention of a particular topic, "1" indicating that the issue had been raised but did not have the full consensus of the group (which enabled the entry of written as well as verbal responses), and "2" indicating apparent consensus. ("Apparent consensus" is obviously a soft measure. If the topic at hand was at all controversial or if any hesitancy was evident, the facilitator asked, "Does everybody agree about this?" In the several incidences of individual written or verbal reservations, the score was reduced to a 1.)

Focus Group Results

The variable scores were totaled and then ranked by score. The *complaints most heard in the community* were pain, which was associated with arthritis/rheumatism and backache, allergies and heart disease. The focus groups cited diseases related to aging and the frail elderly (Alzheimer's disease, circulatory problems, cardiovascular disease and "just getting old") at the top of their list of "serious health problems" in the county.

The biggest single vote-getter in the *focus groups' views of serious illness* was alcohol abuse. This was a surprise to the facilitators, who had not seen its significance in their own notes; the quantitative analysis revealed consistency in the perception of the alcohol problem in all but the community-based groups. (Loyalty to community, the taboo against alcohol in fundamentalist religion, concern over family embarrassment and privacy, and/or fear of recrimination are believed to have prevented the alcohol issue from being raised in the ten community-based groups.)

Stress-related symptoms such as headaches and stomachaches were ranked second to alcohol. A number of informants talked about the stress felt by farmers, who must produce to make payments on farm equipment and land taxes before they can provide food, shelter, and medical care for their families. The harsh demands of life for many county residents caused depression to be scored within the top five ranked health problems. Teachers said that family problems caused stress-related illness among children and depression, especially among

high school students who see little opportunity after graduation: "They want to stay in the area, but have to leave if they are going to find jobs."

Lack of preventive health care, care of self in the early stages of an illness or injury, poor diet and poor parenting, hygiene, and abuse and neglect ranked highest on the *causes of health problems* list. A number of informants talked about damage being done to the family and especially to children by both parents working. Many families now are single-parent families, causing even greater financial and emotional stress. Focus groups with elementary school teachers provided insights on what appears to be an eroding family system and its impacts on children:

> In one class, every child was from a broken home. Kids from single-parent households have the greatest behavioral problems: fighting, pinching, biting, hyperactivity.

> The stress comes from just trying to survive. They [the children] are always hearing about how hard it is to get by from their parents. Many [children] work in the tobacco fields and in tomatoes.

> The kids don't sleep at night. They just come in and put their heads down on the desk—and we let them sleep. They can't learn anything when they're that tired. We just let them sleep. Some of them stay up because they're working—in tobacco in the evening or digging night crawlers to sell to tourists.

> Some stay up all night watching television. There's nobody there to set limits . . . nobody there to parent.

> The kids come to school tired. They're not getting breakfast. Ninety percent of the parents told me that if their kids got breakfast, they got it at school.

> Many kids are unsupervised in the afternoons and evenings. Sometimes it's because the parents work the third shift.

> Some children as young as the third grade are preparing their own meals.

> Some as young as the third grade get up themselves and then have to dress and feed their younger brothers and sisters before school.

> Kids are affected by alcohol abuse—both in terms of witnessing heavy drinking and by being victims or witnesses of physical abuse accompanied by drinking.

The kids get knocked around at home, so they do it to each other at school.

We cannot do as much teaching now as we did ten years ago—we spend much more time now in counseling students and in trying to control their behavior.

Poor parenting was felt to have serious impacts on children's health:

Fifty percent of the kids at this school do not get taken to the doctor.

Mothers work now. They send sick kids to school. Single parents can't afford to lose a day's work and stay home with a sick child.

Fifteen out of the twenty-five kids in my classroom have never seen a dentist.

One boy has a large cavity in a front tooth and he always tries to hide it by holding his lip down over his tooth.

In my first ten years, I never made a report to the Department of Social Services for suspected abuse. Now we have to report four or five cases every year in this one school alone.

The teachers' comments relating to abuse were echoed by other groups. Scout leaders said:

Single parents and young parents are causing a lot of abuse, especially these young mothers—babies having babies.

Of the 250 Girl Scouts in our troops we referred 16 to Protective Services last year.

A Department of Social Services Protective Services worker reported:

N came to me and said "Now, you know J's a good fellow and doesn't mean any harm. You know this morning he's praying with his children. He really loves them." I said, "You should have been there last night when he was pointing his shotgun at his wife and me and his kids had run off to hide in the woods."

Comments by teachers as well as by other focus groups played a major role in a Community Advisory Board decision to create the COPC "Parent Team" described below.

The economics of medical care topped the list of *perceived barriers to health care*. The high costs of visits to medical facilities, especially for people on fixed incomes, the costs of medicines, insurance, and transportation were highly ranked. Consequently, the groups seen as not having access to adequate medical care were the elderly, working people who are unable to afford the high costs of private medical insurance and yet are ineligible for Medicaid assistance, as well as children and teenagers whose parents cannot get them to the medical centers because they can't afford it, don't have a car to transport them, or are at work.

Preventive health education scored highest on the groups' ranking of *needed solutions*, followed by transportation for the elderly and for children, education on how to utilize existing health care services, preventive care, parenting and nutrition, expanded home care services for the frail elderly, and development of support groups for parents.

Other Sources of Data

The focus group data was developed alongside epidemiological statistics on mortality and morbidity and on demographic, economic and social data provided by both federal and state agencies. The results of this information are evident in the previous description of the county. Perhaps the most interesting finding in the epidemiological data was that Madison County is not unusual—its overall health is no better or no worse than other American counties. What appeared to be a problem with a high rate of strokes (92.17 per 100,000 compared to a national average of 62.5) disappeared when seen in terms of "Years of Life Lost," a measure that subtracts an age at death from 75. There were virtually no years of life lost to stroke in Madison County, indicating that people die of stroke after the age of 75. Elevated rates for deaths from diabetes indicated a need for more attention to medical care and monitoring, as well as diet. The elevated pneumonia/influenza rate (51.84 compared to a national 29 per 100,000) suggested greater attention ought to be paid to respiratory illness and preventive measures, such as regular influenza vaccinations.

It is important to note, however, that epidemiological data based on rates of illness was found to be problematic in our COPC community assessment because frequencies are so small at the community level. For example, in 1986 six people died of diabetes in Madison County. For a county of 17,500 people

the rate per 100,000 would be 34.28. If only two more people had died, the rate would have jumped to 45.7.

Turning the Data into Action I:
Agency Responses and Interventions

Facilitators had promised the focus groups that they would feed back complaints about services to agencies. The Hot Springs Health Program was told it needed to work on changing its image as a "poor person's clinic." This image, that stems from its early years when it received federal funds, is far from the current reality of it being a private group medical practice. The "poor person's clinic" view had also contributed to the idea that its physicians were "not good enough to be in private practice." In effect, the practice has had to deal with the history of Madison County being portrayed in the state media as poor and backward and the fact that some local residents had bought into this stereotypical view to the point where they could not believe in the quality of their own medical service. The program's administrators and physicians also were told of complaints about scheduling and long waiting periods, and "cold" receptionists at one of the four medical centers. The complaints were addressed, at least partially, by the computerization of appointment schedules and medical records. A workshop was held for the receptionists and clinical assistants, that enabled them to vent their frustrations with doctors' behaviors in a meeting with the physicians, and an ongoing biweekly meeting was established at the center to process stress and office problems.

One message from the epidemiological data, that was especially supported by the focus groups with teachers, was a high rate of dental caries among school children. Consequently, a pilot tooth sealant program was developed for all second graders (who are at the age most beneficial for such preventive care). The program was carried out on site in the schools, accompanied by an education component for both the children and their parents, complete with "before and after" questionnaires and a control group of school children in neighboring counties who did not receive sealants. In all, some 400 Madison County children and their parents will benefit from the program. Additionally, seventh graders are receiving education about fluoride and fluorosis, and efforts are being made to assist in the fluoridation of public water systems.

Turning the Data into Action II: Community Organization

Before applying for the Kellogg grant, its authors had invited representatives of county agencies and organizations to luncheons to elicit their ideas and support for the COPC idea. Their enthusiasm sufficiently impressed Kellogg

grant evaluators who chose to fund the Madison project. After being funded, this group became the COPC project's Community Advisory Board or "CAB." It's regular two-and-a-half hour luncheon meetings have become a major place for networking between agencies and groups. In time, the first half hour of the meetings was devoted to informal conversation and eating—which always began with comments about how people never get to see each other and then moved into specific problems and problem-solving unrelated to the COPC effort. The COPC staff found that this informal process was necessary and had to happen before the group could effectively concentrate on COPC business. The lunches are expected to continue indefinitely, beyond the life of the project. In the language of the program, they are a very useful "unanticipated outcome."

In the winter of 1990, the project staff took the Community Advisory Board through a review of COPC theory and goals and the data gathered. Staff also outlined possible interventions, using the oral health project to explain different levels of intervention:

Level 1: Direct interventions: Dental exams and placement of dental sealants by public health dentists and hygienists.

Level 2: Community-based educational/preventive interventions: School-based oral health program for second graders and all parents of K-8 students. Mass media campaign targeting the community-at-large.

Level 3: Interventions promoting changes with legislative policy makers: Support/advocacy for town water fluoridation, working with town and county governments.

(The oral health program had already been organized with Advisory Board approval but without much involvement—the need had been so obvious that the project staff, at the urging of the W. K. Kellogg Foundation, had started work with local dentists and state and county health officials to get this one intervention operating from the outset of the project.)

Following the review and education process, the board was broken down into nominal groups, each of which was asked to list the three most serious health problems in the county, the three barriers or sources contributing to these problems, groups affected by the problems, agencies already working on them and, finally, what interventions would now be appropriate. The Advisory Board decided it wanted to focus on children (the other main option being the elderly) and that, given the problems that affect children—from alcoholism to abuse and neglect—it would be most appropriate to target parents. Board members felt that interventions focusing on parents could impact indirectly but significantly on

issues such as substance abuse, poor parenting and domestic violence. Further deliberations narrowed the target to all parents of newborn babies in a pilot project area to avoid stigmatizing a specific group, such as "high risk families."

A subcommittee was established to assess extant health programs directed at children and to come up with suggestions for new interventions. The children's subcommittee, which included a physician, a hospice social worker, and staff from the Health Department, Mental Health Center and project staff, recommended a lay "Community Health Advisor" program (Service and Salber, 1979) capable of:

1. linking parents with agencies
2. supporting parents in parenting
3. getting health care workers into the communities or homes (for hard-to-reach families)
4. getting first aid and medical supplies to families
5. getting information on preventive care and local resources to families
6. getting parents to educational meetings or classes on health and parenting.
7. begin education on parenting with adolescents (to be addressed in a new health curriculum being implemented at the county high school).

A meeting with the county PTA council was followed by two additional focus groups with parents (one at the Health Department and another at a kindergarten) to both validate previous findings and broaden the support base for a parent's project. Receiving the validation it sought, the Community Advisory Board worked with a single community PTA to create a pilot "parent helper" project. The PTA selected four community women it felt could carry the project to parents of newborns. While one CAB subcommittee wrote a "Resources Guide" of services available to parents, another designed a lay helper training program and a third determined the contents of a medical kit for parents. At the same time, project staff sought Institutional Review Board approval for the project, required consent forms, etc.

The four women, who have come to call themselves the "Laurel Parents Team," were trained in the late fall of 1990. Representatives of some fifteen county agencies were involved, although most of the training was conducted by medical personnel from four agencies. A Mental Health Center therapist and the staff sociologist worked with the women on communication skills and strategies for networking. The trainees themselves provided their own definitions of what would be acceptable in their community: they revised the parents' consent form, a home safety checklist and a brochure describing their program. They went

into the field in December 1990. The continual monitoring that is integral to the COPC process will help them and the agencies behind them adjust and refine services to meet the ever-changing needs of parents and their children.

Conclusion: Sociology's Role in Community Development and Community-based Health Promotion

The Madison county COPC project demonstrates a number of ways in which sociologists can contribute to community-based public health projects and, additionally, work effectively with epidemiologists and other medical service providers. The project's sociologist worked in defining, accessing, and assessing the community, designing and implementing research methodologies, facilitating community group decision-making, networking between agencies and between community-based groups and agencies, and in the training of the "Parent Team" indigenous lay health advisors. He also shared community research data with medical providers in efforts to help them improve their sensitivities and services to clients. He continues to play a role in the evaluation of the project's ongoing interventions and in facilitating the design of new ones.

The most significant contributions provided by sociology to this project appear to be:

1. The idea of community as social fact. Sociology carries unique insights into the power and nature of community (Nisbet, 1953, 1966; Stein, 1960; Warren, 1972). These insights enabled the investigation into the nature and definitions of community in Madison County which provided the framework for all that followed. In identifying and making connections with communities and with key individuals and organizations within them, the COPC staff enabled them to:

- be involved in the initial "brainstorming" that led to the grant application and to the W. K. Kellogg Foundation funding.
- define the nature of "community" in the county, which resulted in the identification of seventy-two in-county neighborhoods.
- articulate its sense and experience of illness, causes of illness, barriers to adequate health care and groups cut off from medical services in those communities (via the focus groups).
- determine possible solutions and priorities for interventions, both in focus groups and in the Community Advisory Board.
- play a central role in the design and implementation of interventions. Schools worked with dentists in the sealant program; community clubs and senior meal sites assisted the county Health Department in an In-fluenza Vaccination Program, and a Parent-Teacher Association took

major responsibility in organizing the Parent Team indigenous lay health
advisor project.
● determine what would be or would not be acceptable to the community.
These decisions impacted everything from research techniques to what
consent forms families involved in the Parent Team Project would be
required to sign.

In sum, a belief in the integrity of community enabled the COPC Executive
Board (made up of doctors and administrators connected with the Hot Springs
Health Program and the Mountain Area Health Education Foundation, and the
sociologist) to surrender considerable control and let the Community Advisory
Board, county agencies such as the Health Department and community groups
like the Laurel PTA determine policy. The community was involved in signifi-
cant ways from the beginning of the program.

2. Research methods. Where an epidemiologist seeks to evaluate commu-
nity health by reference to county, state and national morbidity and mortality
data, the sociologist can ask community residents about their insights into health
problems. Both epidemiologists and sociologists gather data through surveys, but
a growing number of sociologists are impressed by the power of "softer" socio-
logical qualitative methods such as the focus group interview. Focus group data
proved to be more useful in determining needs and policy than epidemiological
data on mortality and risk behaviors.

A second point: Where research elements within both sociology and epi-
demiology may tend to see people as "data," sociological experience in partic-
ipant observation and symbolic interactionist theory illuminate the significance
and power of people's definitions of their own realities. The Madison project
was grounded in community definitions of illness and barriers to good health.
The consequent rapid development and acceptance of project activities are a
product of their "fit" within community definitions and worldview.

3. Concepts of culture and subculture. The sociologist brought to the project
knowledge gained in previous research documenting the differences between the
values and world views of medical practitioners and their rural clients (Plaut,
1988). He consequently was able to advocate the legitimacy of the client point of
view. The fact that local women were able to redesign home safety checklists
(so they would not offend their neighbors) and project participation consent
forms (whose original form contained overwhelming legal detail) indicates the
degree of control given them in relation to "the Ph.D.s and doctors" responsible
for program implementation and evaluation.

4. Researcher as participant. Much of the ability to conduct focus groups, the
mapping and the community facilitation/organizing was due to the sociologist/

community assessment person and the project coordinator having spent more than a decade working in the county. Before the Kellogg project, the coordinator directed programs for the developmentally disabled. The sociologist helped establish a hospice program and had been both a consultant to and board member for the Hot Springs Health Program. Both had helped develop services for victims of rape. Each had earned a measure of community acceptance and trust prior to the project.

In summary, sociology played a significant role in the conceptualization, program development and implementation of the COPC project. Although medical providers, community members and the sociologist came to project with different perspectives, there came a time when they could sit back and reflect on their differences and the connection between those differences and the training provided them by their respective disciplines and life experiences. From that moment on, we seem to have been living by Hylan Lewis' dictum to Elliot Liebow as he set out for Tally's Corner: "The scientific method is doing one's darndest with his (or her) brains, no holds barred" (Liebow, 1967:235).

REFERENCES

Basch, Charles E.
    1987   Focus group interview: An underutilized research technique for improving theory and practice in health education. *Health Education Quarterly* 4/14 (Winter): 411–48.
Cancian, Francesca M., and Cathleen Armstead
    1990   Participatory research: An introduction. Paper presented at the American Sociological Association Convention, Washington, D.C., August.
Eller, Ronald D.
    1982   *Miners, Millhands and Mountaineers: The Industrialization of the Appalachian South, 1930–1980.* Knoxville: University of Tennessee Press.
Flaskerud J. H., and C. E. Rush
    1989   AIDS and traditional health beliefs and practices of black women. *Nursing Research* 38:210–15.
Freire, Paulo
    1970   *Pedagogy of the Oppressed.* New York: Continuum.
Joseph, J. G., C. A. Emmons, R. C. Kessler, C. B. Wortman, K. O'Brien, and C. Schaefer
    1984   Coping with the threat of AIDS: An approach to psychosocial assessment. *American Psychologist* 39:1297–1302.
Krueger, Richard A.
    1988   *Focus Groups: A Practical Guide for Applied Research.* Newbury Park, Calif.: Sage Publications.
Kuhre, Bruce E.
    1976   Toward a definition of Appalachia. In Bruce Ergood and Bruce E. Kuhre, (eds.), *Appalachia: Social Context Past and Present.* Dubuque: Kendall/Hunt Publishing Company.

Liebow, Elliot
    1967   *Tally's Corner: A Study of Negro Streetcorner Men.* Boston: Little, Brown and
              Company.
Maguire, Patricia
    1987   *Doing Participatory Research: A Feminist Approach.* Amherst: Center for Interna-
              tional Education, School of Education, University of Massachusetts.
McCarthy, Coleman
    1990   A very profitable medical practice. *The Washington Post,* June 2, A19.
Merton, Robert K., Marjorie Fiske, and Patricia L. Kendall
    1990   *The Focused Interview: A Manual of Problems and Procedures.* New York: The
              Free Press.
Morgan, David L.
    1988   *Focus Groups as Qualitative Research.* Newbury Park, Calif.: Sage Publications.
    1989a   Adjustment to widowhood: Do social networks really help? *The Gerontologist*
              29:101–7.
    1989b   Caregivers for elderly Alzheimer's victims: A comparison of caregiving in the
              home and in institutions. Final report to the AARP/Andrus Foundation.
    1990   Designing focus group research. Paper presented at a workshop on focus groups at
              the American Sociological Association Conference, August 13, 1990, Washington,
              D.C.
Nisbet, Robert A.
    1953   *The Quest for Community.* New York: Oxford University Press.
    1966   *The Sociological Tradition.* New York: Basic Books.
North Carolina Agricultural Extension Service
    1988   Madison County, North Carolina: County overview. *Madison County Program
              Statement—1983–87.*
North Carolina Department of Public Instruction, Division of School Planning
    1987–88   *Madison County: A Special Report 1987–88.* Raleigh.
North Carolina Department of Environment, Health and Natural Resources
    1988   *Community Diagnosis: County Data Book for Madison County.* Raleigh.
North Carolina Division of Statistics and Information Services
    1989   *Detailed Mortality Statistics.* Microfiche for Madison County 1983–1988. Raleigh.
North Carolina State Data Center
    1986   *Profile: North Carolina Counties.* Office of Budget and Management, Raleigh.
    1988   Older adults: 1980 census. *Newsletter* 10/3 (December). Chapel Hill: Institute for
              Research in Social Science.
    1989   Bureau of Economic Analysis estimates of per capita income. *Newsletter* 11/1
              (July). Chapel Hill: Institute for Research in Social Science.
Overall, Nedra, and Julie Williamson (eds.)
    1987   *Community Oriented Primary Care in Action: A Practice Manual for Primary Care
              Settings.* Berkeley: University of California, School of Public Health.
Plaut, Thomas
    1988   Cross-cultural conflict between providers and clients and staff members. *Appala-
              chian Mental Health.* Lexington: The University Press of Kentucky.
Service, Connie, and Eva J. Salber
    1979   *Community Health Education: The Lay Advisor Approach.* Durham: Duke Univer-
              sity, Health Systems Inc.

Stein, Maurice R.
    1960   *The Eclipse of Community, An Interpretation of American Studies.* New York: Harper and Row.
Taylor, Henry, and Carl Taylor
    1989   American practicioners and the global primary care movement. *Maryland Medical Journal* 38:849–52
Taylor, R. R.
    1989   Pity the poor gatekeeper: A transatlantic perspective on cost containment in clinical practice. *British Medical Journal* 299:1323–25.
Trostle, James
    1986   Anthropology and epidemiology in the twentieth century: A selective history of the collaborative projects and theoretical affinities. In Craig R. Janes et al. (eds.), *Anthropology and Epidemiology.* Boston: D. Reidel
Wallerstein, Nina, and Edward Bernstein
    1988   Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly* 379:94
Warren, Roland L.
    1972   *The Community in America.* Chicago: Rand McNally.

The Sociological Practitioner in Organizational Health Promotion Programming

Linda R. Weber
Glassboro State College

ABSTRACT

In this paper, the roles of the sociological practitioner will be investigated as they apply to the rapidly growing field of organizational health promotion. Health promotion programs include a combination of educational, organizational, and environmental activities designed to support health-conducive behavior within the work setting. Such programs usually include weight reduction programs, aerobic exercise classes, blood pressure monitoring and so on. Theoretically, the ideas of Mead and Becker are investigated as one approach to the understanding of health behaviors. Methodologically, the utilization of needs assessment and evaluation tools provide integral information for the development of a program specifically tailored to meet the needs of an organization. Finally, the clinical sociologist, as a practitioner, can work to design successful programmatic interventions for the worksite. The field of helath promotion provides a number of roles within which sociologists could find viable employment.

Introduction

The advent of organizational interest in promoting the health of employees provides sociological practitioners with an opportunity to utilize theoretical, analytical, and interventionist skills in an emergent job market. Wellness programming centers around health promotion rather than disease prevention. As one founder of health promotion ideas, Dunn (1961) attempted to devise a

new way of thinking about health by differentiating the disease process, which is dominated by medical practitioners, from the process of health promotion, which is dominated by social scientists, educators, and others. Conrad (1988) defined health promotion as a combination of educational, organizational, and environmental activities designed to support behavior conducive to the health of employees and their families. Health promotion activities traditionally include the provision of exercise facilities, the addressing of specific health problems such as hypertension, the assessment of overall health status, and the investment in comprehensive health promotion programs (Breslow, Fielding, Herrman, and Wilbur, 1990). Weight reduction programs, aerobic exercise classes, blood pressure monitoring, general health education, nutrition programs, and stress management programs, are examples of typical health promotion programs at the work site.

Employers have become increasingly involved in health promotion activities. Hollander and Lengermann (1988) have indicated that two-thirds of the Fortune 500 companies have wellness programs; the other third have plans to start programs. In addition, two-thirds of worksites with over 50 employees and one-fifth of companies having between 50 and 100 employees have reported involvement in one or more areas of health promotion (Fielding and Breslow, 1983; Davis, Rosenberg, Iverson, Vernon, and Bauer, 1984; Fielding and Piserchia, 1989). In one study, 78 percent of all companies in California were reported to have at least one health promotion program (Fielding and Breslow, 1983). Participation rates of employees for on site programs range from 20 to 90 percent (Fielding, 1984; Kiefhaber and Goldbeck, 1986).

Escalating health care costs and employee absenteeism are two motivating forces behind organizational involvement in health programming. Tenneco reported that the average claim for nonexercising females was $1,535, compared to $639 for exercising females, with a similar differential reported for males (Stockel, 1988). Smokers cost employers an annual estimated $624 to $4,611 more than nonsmokers in increased medical costs, absenteeism, replacement costs, maintenance, property damage, other insurance increases, and lower productivity (Kristein, 1980; Weis, 1981). Cardiovascular disease and hypertension result in an estimated 26 million work days lost annually (LaRosa, 1983). Finally, excessive drinking has resulted in an estimated 19 billion work days lost per year (Cunningham, 1982).

Within this paper, the primary roles of the sociological practitioner as a theoretician, as a researcher, and as an interventionist will be applied to the health promotion setting. The intent of this overview is to provide sociological practitioners who are new to this field with some basic information about the nature of health promotion and the possible roles available for their adoption.

The author's comments are derived from experiences working with a small city government in the southeastern United States while developing a health promotion program for its municipal employees.

The Sociologist as Theoretician

Sociological practitioners with training in classical and contemporary theory can provide an appropriate integrative conceptual basis for the coherent introduction, testing, and revision of health promotion ideas. The philosophical underpinnings of wellness programming, which tend to emphasize individual action and self-responsibility, can be expounded on utilizing a micro-level perspective. In this section, emphasis will be placed on micro-oriented theoretical approaches utilized by this author, including Mead's (1934) symbolic interactionist perspective and the health belief model.

Mead's Symbolic Interactionism

Mead's (1934) symbolic interactionist perspective, as expanded by Turner (1987) into a general interactionist model of motivation, can be used to provide one understanding of health promotion activities at the worksite. At the basis of this approach are the ideas of self-directed action, identity, and the definition of the situation; the relationship of these variables is depicted in Figure 1. Each of these ideas will be further developed, below.

The self-directed act.

Mead's emphasis on the self-directed act, the basis of Turner's (1987) interactionist model of motivation, is based on the concept of reflexive thinking which entails the ability of the self to be viewed as an object. As such, one can observe one's self, can engage in an assessment of one's actions in relationship to the actions of others, and can form a response (Mead, 1934). Together, these abilities form the self-directed act.

How is the self-directed act important in health promotion? If the individual develops the ability to view the health component of one's self, to be referred to as the health self in this article, then the individual will engage in activities which reflect the assessment of self as determined by others. If the assessment by others is negative, the individual may choose to act in such a way to reverse this assessment in order to achieve a more ideal or "fit" conception of self. The health self is manifested in and influenced by the physical body, for it is this body that others are reacting to in social interactions such as group exercising (Glassner, 1989; Freedman, 1986). If the health arena is extended to the organizational
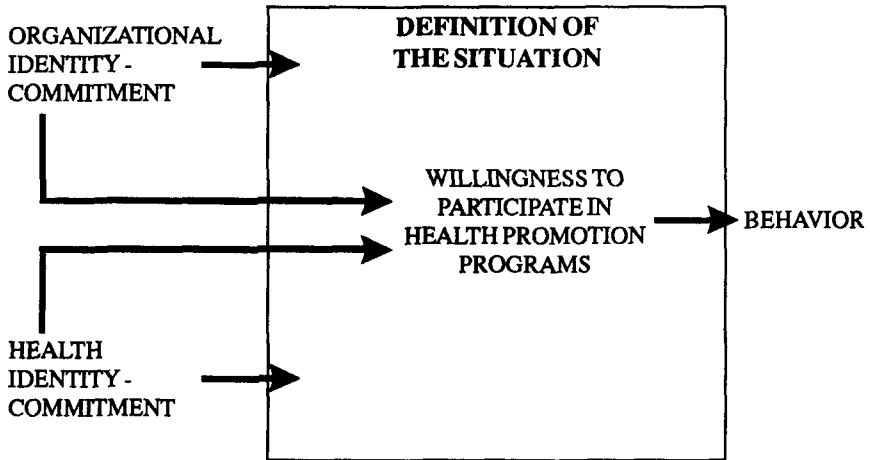
Figure 1. The relationship between identity and behavior

role, as is the case within organizational health promotion programming, then organizational responses to the individual's health state can also be expected to become important in determining both one's health self—that part of the self which corresponds to one's organizational role—that is, the organizational self.

Identity.

Identity is the content of the self-concept. The Iowa School of structural interactionists defines identity as internalized roles (Gecas, 1982). Role identities are not all equal, but differ in prominence and in importance. Therefore, the self-concept can be viewed as a hierarchical arrangement of role identities (McCall and Simmons, 1978; Stryker, 1968).

The extent to which an identity influences behavior is signified by commitment. Cheney and Tompkins (1987) assert that the "degree" of commitment refers to how closely behavior is "tied to self" or incorporated into the self. Thus, the extent to which an organizational identity is incorporated into the self determines the extent to which behaviors are congruent with the stance of the organization. Likewise, the extent to which a health identity is incorporated into the self determines the extent to which behaviors emerge that are congruent with significant others in the individual's health arena. Within the situation under analysis, the stance of the organization and the stance of significant others

within the individual's health arena can usually be defined as supportive of individual participation in health promotion activities.

   The definition of the situation.

   The definition of the situation influences behavior. W. I. Thomas expressed the belief that "preliminary to any self-determined act of behavior there is always a stage of examination and deliberation that we may call the definition of the situation" (1931:47). When one defines a situation, one represents the situation to the self symbolically and then makes a self-directed response. Thus, the subjective rather than the objective factors of a situation are the primary determinants of behavior. One's identity, as the conglomeration of values, roles, and behaviors that the actor believes to be authentic, serves as a filter through which selective perception and recall occur. Hence, the definition of the situation is influenced by one's identity.

   A synthesis of the definitions of both the work situation and the health situation results in a definition of the health situation at the work site. The theme or attitude of importance within this definition is the willingness of the individual to participate in a wellness program. The behavior of importance to the clinical sociologist is that of participation in the health promotion program.

The Health Belief Model

   The Health Belief Model (HBM) is another approach to the understanding of the practice of preventive health behaviors. Initially formulated by Rosenstock and his associates (Rosenstock, 1966) and revised by Becker and his associates (Becker, 1974; Becker, Drachman and Kirscht 1974; Becker, Haefner, Kasl, Kirscht, Maiman, and Rosenstock, 1977; Becker and Maiman, 1975; Becker, Maiman, Kirscht, Haefner and Drachman, 1977), the health belief model currently proposes that health preventive behaviors are associated with the following factors: (a) a general tendency to engage in health behaviors, (b) the level of susceptibility of the particular illness or condition, (c) the level of severity of the consequences of the disease on biological or social functioning, (d) the potential benefit of the health directives in preventing or reducing susceptibility and/or illness, and (e) the existence of physical, psychological or social barriers that might affect initiating and/or continuing the health directive. Studies have demonstrated the utility of knowing the health beliefs of clients when attempting to predict health behaviors, especially compliance (Haynes, Taylor and Sackett, 1981). In addition, health beliefs have been shown to be moderately associated with the adoption and maintenance of physical activity (Sallis, Haskell,

Fortmann, Vranizan, Taylor and Solomon, 1986) and the practice of protective health behaviors (Harris and Guten, 1979).

The health belief model and the identity model may be related. Identity, as stated, appears to be an important factor in the formation of attitudes/beliefs. The identity model encompasses beliefs/attitudes within the definition of the situation. Within interactionist theorizing, beliefs logically emerge from identity. Thus, the proposed identity model and the HBM may be complementary components of a larger model which better explains health behaviors.

The Sociologist as a Researcher

The sociological practitioner brings valuable research skills to the organizational setting. The utility of needs assessment skills and evaluation skills in health promotion programming will be presented in this section.

Needs Assessment

In order to develop programs that adequately address the needs of employees, organizations must go through an initial information collection stage. Information which represents the present health status of employee, the at-risk status of employees, the type of programs in which the employees are willing to participate, and potential organizational barriers to health-conducive behaviors is needed.

The health status of employees.

An overall definition of health includes physical, mental, and social components. According to the World Health Organization (WHO), health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1948). Physical health includes both physiological dimensions (e.g., blood pressure) and physical components (e.g., the ability to walk), mental health refers to the individual's state of mind, and social health refers to the quantity and quality of social contacts. The emphasis on an overall state of well-being makes the WHO definition of health complementary to the orientation of wellness programming.

Due to the problematic nature of objective health status measures and the nonexistence of measures of the physical health status of the general population (Patrick, Bush, and Chen, 1973; Sackett, Chambers, MacPherson, Goldsmith and Mcauley, 1977), this researcher utilized a subjective measure of health. Subjective measures of health complement the interactionist approach by emphasizing the individual's perception of his/her health. Although self-reported indices of

health are widely used, a controversy does exist over the validity of these mea-
sures in comparison with objective measures. However, a number of researchers
support the reliability, predictability and validity of subjective measures (Singer,
Garfinkel, Cohen, et al., 1976; Mossey and Shapiro, 1982; Goldstein, Siegel and
Boyer, 1984).

In addition to this measure of physical health status, this researcher, after
reviewing innumerable measures of mental health status, chose to use a 28-
question version of the General Health Questionnaire that assesses anxiety, som-
atization, social dysfunction, and severe depression (Goldberg and Hillier, 1979).
In his study of the different forms of the General Health Questionnaire, Banks
(1983) concluded that the 28-question version had superior performance con-
cerning misclassification rate (15%), sensitivity (100%) and specificity (84.5%)
using a cut-off point of 5/6.

The "at-risk" status of employees.

Another factor that merits inclusion in the health needs assessment is an
indicator of the health risk status of employees. Health risk assessments (HRAs),
which have been developed for this specific purpose, are tools utilized to de-
scribe an individual's chances of dying or of acquiring specific diseases within
a specific period of time (usually ten years). Currently, HRAs emphasize the
measurement of risk for the development of cardiovascular disease. A risk score
is calculated based on measures that may include weight, height, age, smoking,
cholesterol levels, lifestyle issues and so on. Risk assessment indicators are
distinctly different than health status indicators. HRAs are based on probabili-
ties derived from epidemiological studies, rather than diagnoses. For example,
a cardiac risk indicator score may conclude that an individual is at high risk
for developing coronary artery disease within ten years, while the individual's
present coronary status may be excellent, good, fair, or poor.

The HRA has both organizational and individual uses. From the organi-
zational perspective, the HRA can gauge the risk of the population for some
defined preventable disease. In addition, the HRA can be used in combination
with morbidity and mortality statistics to provide a basis for a health program
specifically tailored to meet the needs of the organization.

The HRA utilized should be chosen to reflect targeted programming areas.
A list of health risk assessment tools can be ordered from the Center for Disease
Control, Bureau of Health Education, 1600 Clifton Road, N.E., Atlanta, Georgia
30333. When choosing an HRA, the researcher should be aware of the following:
(1) the validity of the instrument is closely related to estimation procedures with
mortality risk, morbidity risk, overall heart disease risk, life expectancy, and
general health status in order of decreasing validity, (2) the validity of an HRA

increases with the number of questions used to assess risk, (3) the adjustment of risk scores for age renders them more valid (Smith, McKinlay, and Thorington, 1987), (4) the charges for questionnaires range from zero to $40, (5) the HRAs can be self-scored or computer-scored, and (6) the investment in a computer package is cost-efficient for an organization which plans on long-term use.

The assessment tool utilized by this researcher measured the risk for the development of cardiovascular disease. The American Heart Association's RISKO instrument was chosen due to its low cost and its apparent reliability as tested by researchers in the assessment of HRAs. Measures of height, weight, cholesterol level, age, cigarette smoking and systolic blood pressure are the components of this health assessment tool.

In terms of its applicability to individuals, the HRA can be referred to at will by an individual, discussed with the family, and used to monitor progress (Fielding, 1984). The theory behind the HRA complements the interactionist schemata previously detailed due to the provision of a tool to aid the individual in incorporating the health self. The ability to do this will lead to a further ability to reflexively view this health in an accurate manner (Glassner, 1989). When an individual realizes how his/her self is viewed by others (e.g., the health care community), actions that confirm or disconfirm this self-concept should be forthcoming.

Program interest.

The initial identification stage of planned organizational change provides an opportunity to investigate the nature of programs that are of interest to employees, features that would prevent participation, and times that would be convenient for optimal usage. Through this needs analysis, the following information should emerge:

- those programs that are of no interest to employees;
- those programs with which the organization could reach a large target audience; and
- avenues for intervention that would encourage greater involvement.

Together, proper utilization of the information provided by the employee will lead to a program specifically tailored to meet the needs of employees.

This researcher assessed willingness to participate in blood pressure monitoring, weight reduction programming, aerobic exercise programming, nutrition awareness seminars, mental health sessions, stress management classes, first aid classes, on-site nursing services, and personal growth and development programs. Through such an assessment, this researcher was able to initially target

mental health, weight reduction, smoking cessation, and aerobic exercise within this worksite.

Occupational safety and health.

The organizational environment is often related to the occurrence of accidents and the appearance of illnesses among employees. As such, an assessment of existing and potential occupational hazards provides some important information for the developers of a health promotion plan. Work accidents account for an estimated 5 million injuries, with 2.2 million of these accidents being permanently disabling and 13,000 resulting in death (Hills, 1987). In addition, approximately 100,000 Americans die each year from occupation-related diseases with 390,000 new cases being diagnosed each year (Elling, 1986). Although often ignored, workers' self-report of health hazards has tended to be highly reliable (Nelkin and Brown, 1984).

Evaluation

A few scientific evaluations of worksite health promotion programs have emerged. The Johnson and Johnson "Live for Life" program, which includes annual blood screening, nutrition programs, weight control, stress management, and blood pressure controls, conducted an evaluation by comparing sites with comprehensive programming (e.g., the experimental group) with sites that had only performed a health risk assessment (e.g., the control group) (Breslow, Fielding, Herrman, and Wilbur, 1990). With respect to vigorous exercise, the experimental group demonstrated a 20 to 30 percent increase in employees reported participating in regular vigorous exercise after the initiation of the program compared to 0 percent prior to the program implementation. In addition, people who participated in one or more sessions of the smoking cessation program reported a quit rate of 31.6 percent at the two year follow-up, as compared to 17.4 percent in the control group. A 9 percent reduction in reported sick days was reported for the experimental group, as compared to a 14 percent increase for the control group. Finally, the annual return on the investment was reported to be approximately 30 percent, as reflected in the stemming of increases in inpatient costs to a twofold increase for the experimental group as compared to a fourfold increase for the control group during the five-year study period.

Control Data's "Staywell" program has also been evaluated. Health care benefit payment reductions have been confirmed within the Staywell program (Naditch, 1984). Compared to nonsmokers and those who quit smoking more than five years ago, smokers claimed 25 percent more benefit payments and

utilized twice the number of hospital days. In addition, sedentary individuals' claims averaged $436.92, with .57 hospital days, as compared to active individuals' claims of $321.01 with .31 hospital days.

Sociological practitioners can assist the organization in evaluating the overall health promotion program. Within this section, a brief overview of systems-oriented evaluation is provided as it applies to health promotion programming. An in-depth presentation of the evaluation process will not be attempted, since many excellent books on evaluation exist (Suchman, 1967; Attkisson, Hargreaves, Horowitz and Sorensen, 1978).

Systems evaluation focuses on the analysis of input, process, and output units. A level of effort or input involves the amount and distribution of resources into programs; examples of such measures include the sources of income, sources of expenditure, number of clients, and type of clients.

An output or performance approach involves an assessment of the program's outcomes and the effectiveness of the program in obtaining its specified goals. Potential organizational and client goals are usually reflected in the needs assessment data. At the organizational level, these goals may be a decrease in health insurance monies paid out, an increase in job satisfaction, a decrease in job turnover, a decrease in absenteeism, and so on. Goals at the client level should also be assessed; if clients are not reaching personally defined goals for participating in the health promotion program, then participation may cease. At the client level, goals may include decreasing health risk status, improving health status, and facilitating of mobility within the organizational setting. Obviously, organizational goals and client goals may overlap, as is hoped in the case of an increase in health status.

The process approach emphasizes the means utilized to obtain a goal. Focus is placed on the process itself, rather than on the outcomes of such a process—for example, an employer's utilization of money and staff (input) to train individuals in weight-reduction technique (process) to decrease health risk status (outcome). Within this scenario, training in weight-reduction technique would be assessed to see its effectiveness (i.e., actual weight lost). Process approaches may also include policy approaches (e.g., a no-smoking policy at the worksite); the effectiveness of a policy can be assessed through monitoring of compliance at the worksite.

Once the concern or focus of the evaluation has been delineated, it is possible to outline specific evaluation questions. Questions that encompass concrete measurable phenomena are better able to be used as measurements of goal attainment. For example, general questions geared to evaluate changes in employee health risk status could include the following:

1. At the input level: How many clients are presently at risk?
2. At the process level: Have clients stopped smoking, lost weight, etc.?
3. At the outcome level: Do clients have a lower risk status after programming?

The Sociologist as an Interventionist

The clinical sociologist, whose primary emphasis is intervention, can aid the organization in its attempt to develop and implement a health-promotion plan. The sociologist, in conjunction with a committee of employees representing both management and labor, is a viable guide for the change process. According to Felix, Stunkard, Cohen, and Cooley (1985), the selection of enthusiastic employees is the key to the successful establishment of a health-promotion program.

Designing and Structuring the Change Effort

The direction that a change effort takes is an important factor in determining its success. In designing and structuring a change effort, making a distinction between a policy and a program approach becomes important. Designing a change effort "includes defining the purpose and nature of the change intended, creating a delivery system, and specifying their relationships to each other" (Kettner, Daly, and Nichols, 1985:141).

The purpose of the change effort is reflected in the goals and the objectives. Common goals for a work-site health-promotion program might include a reduction in health expenditures for employees and an increase in the health status of employees. Organizations may relate these goals by inferring that an increase in the health status will ultimately result in a decrease in health expenditures. For example, the goal for the health-promotion plan devised for municipal employees by this interventionist was "to create a positive atmosphere that promotes the physical, social, and emotional well-being of the city employees while stemming the increase in health-care costs to the city."

Each goal has enabling factors or processes through which objectives may be met; these processes may include a program and/or policy approach. For example, the implementation of a weight reduction program, an aerobic exercise program, and so on may be the means through which an increase in health status can be achieved. Together, these programs will enable the organization to achieve its objective of increasing the health status of employees.

Policy approaches establish the principles and guidelines utilized during the change effort (Kettner, Daley, and Nichols, 1985). Policy design requires

consideration of the population to be affected, the provisions of the policy, the method of implementing the policy, and the funding of the policy initiatives. For example, the municipal organization that was studied proposed restructuring its absenteeism policy in order to provide one incentive for health promotion. One policy provision was that one paid vacation day would be given as a bonus to employees who were not absent from work for six months. The implementation of the program was made the responsibility of the personnel department. Either existing resources or special organizational fund-raising events would provide funding for this initiative.

The program approach, in contrast, includes program designing, job designing, and program structuring (Kettner, Daley, and Nichols, 1985). The designation of inputs, process, and outputs make up the program design. Inputs include resources and needs necessary to program implementation. Process includes the means utilized to achieve an outcome such as services to be provided, and methods of intervention may be emphasized here. Finally, outputs include the change or the quality of life desired for the organization and/or individuals involved. For example, in the designing of a stress-management program, the money to hire a stress-management counselor and space for stress-management classes must first be accessed. One crucial decision is whether and how organizational change should be included as part of a stress-reduction program. The goal of a reduction in anxiety for city employees could be achieved through both organizational and individual changes.

Patton, Corry, Gettman, and Graf (1986) suggest a number of roles that have evolved in health promotion, such as managers, planners, supervisors, educators, exercise leaders, motivators, counselors, promoters, assessors, and evaluators. The trained sociologist may find employment in any of these roles or as an organizational change agent. For example, clinical sociologists have worked as family therapists and as individual therapists (Glassner and Freedman, 1979). Given that one sociologist can not do everything, the creation of an interdisciplinary team to provide services is a necessary outcome in health promotion.

After the program design has been completed, a job design can then be created while taking into account the amount of socialization required for an individual to be effective in the task at hand. One position created for the city was that of mental health counselor. As a one-fifth time position, the primary responsibility of this counselor was the provision of on-site, short-term mental health services in the form of stress-reduction classes for labor, management, police and fire departments. A master's degree in social psychology and/or counseling, experience in management of caseloads, experience in running stress-reduction

classes, and knowledge of police and fire department employee stress areas were the minimum qualifications.

Program structuring is the final phase in the development of a change effort. What is the relationship between specific jobs? Where does the program fall in relationship to the organization as a whole? Who or what department will be responsible for overseeing the programs? Will that department oversee all of the program, or just part of them? Organizational charts developed around these relationships, which reveal linkages to other departments or corporate officials, are one way of organizing the structure of a health-promotion program. Within the city being studied, it was decided to develop a wellness department whose director would report to the city council. The decision to not include the wellness department in the personnel department was a political one. Within this city, the personnel department head and the health coordinator were housed in separate departments. The health coordinator had voiced opposition to anything but the curative approach of the current health insurance policy. As such, it was crucial to keep the health coordinator from exercising control over the health-promotion plan.

Once the process issues have been delineated, the creation of a service-delivery system becomes feasible. The service delivery system incorporates those services that will be provided and by whom. Within the city studied by this researcher, the city hospital, skilled municipal employees, and contracted workers could provide the needed services. The services would be provided on-site with funds allocated by the city government.

A Note on Ethics

As with any change effort, ethical issues must be taken into consideration. Many of these ethical questions surround the tendency to focus on the individual as a source of change rather than the organization (Castillo-Salgrado, 1984). Allegrante and Sloan (1986) present four dilemmas that confront workers in health promotion. Each of these dilemmas will be discussed, below.

The Dilemma of Conflicting Loyalties

Organizational goals may conflict with the health needs of employees. The professional thus may become caught between focusing effort either on indi-vidual change or organizational change. While individual change efforts may not fully address the cause or nature of the problem, organizational change efforts may offend the authority or structural values of the employer. Obvi-ously, focusing change efforts solely on employees will result in the unnecessary

development of employee resentment. As such, change efforts could be geared to include change at both the organizational and individual level; Lovato and Lawrence (1990) suggested that both individual and organizational issues should be addressed in the optimal health-promotion arena. However, organizational change may be more difficult to enact than individual change. For example, the researcher was invited by management to initiate the investigation into the feasibility of developing a health-promotion plan. Although the researcher focused on the employee as a predominant source of change, organizational/ environmental issues were also addressed by focusing on both policy changes and nonthreatening environmental changes, such as a no-smoking policy and removal of cigarette machines, respectively. As the change effort becomes more accepted and supported, hazardous work conditions may then be better addressed.

The Dilemma of Blaming the Victim

Health promotion programs, which tend to focus on the reduction of risk behaviors, imply that the individual is responsible for his/her illness. Thus, the individual is blamed for something that may or may not be his/her responsibility. Even health care workers would not claim that they are positive about the origins of disease. In a situation where individuals do not have complete control, blame should not be easily assigned. However, given the tendency to assign blame, the manifestation of blame in punishment (i.e., refusal to promote someone who is in ill health) should be avoided. Although this researcher did not confront such a problem, the potential legal ramifications of discrimination of this sort appear to warrant discouragement from adopting this approach.

The Dilemma of Voluntariness or Coercion

The circumstances under which an organization can become ethically or morally justified in using coercion to bring about organizational change are ambiguous. Minkler (1978) proposed that coercive means are justified if a harmful situation exists and noncoercive means have been unsuccessful in rectifying the situation. Since the structure of work organizations and the economy are conducive to ill health, coercive means that focus on individual change are difficult to justify. Overall, the health promotion program devised by this researcher was based on voluntary participation, with the exception of the no-smoking policy. Given the documentation of the ill effects of passive smoking, this restriction did not seem unjustified.

The Dilemma of Unintended Consequences

Health-promotion program philosophies have resulted in a reduction of health benefits in some organizations. In addition, screening technologies have created a potential for abuse and/or misuse of information. For example, employees with health problems may not be hired or may be fired by the organization. These detrimental consequences were never intended to become a part of health-promotion programming. For example, the researcher had to confront the role that drug testing would play in the health-promotion program. The researcher decided not to include illegal drug use/abuse issues in both the needs assessment and the health-promotion plan in order to avoid the stigma of implied coercion being applied to the health-promotion program.

Researcher versus Interventionist

This researcher proposes an additional ethical dilemma of particular concern for the sociological practitioner: the dilemma of researcher versus interventionist. During the needs assessment, some potential problems of an individual (e.g., mental health problems) may surface. The researcher ethic is to be objective and not to analyze data as it is being collected. On the other hand, the interventionist ethic, especially if the researcher is also a counselor, mandates that the researcher/clinician intervene and assist the individual. In so doing, would the researcher/clinician violate either his/her role as a researcher and/or the individual's right to privacy?

This researcher/clinician chose to finish the interview and then asked the individual whether s/he had problems s/he would like to discuss. One method used to approach the topic (e.g., depression) was with a general question, such as, "It looks like you've been feeling pretty down lately. Would you like to talk about it?" If the individual expressed interest in discussing the issue, the researcher/clinician proceeded to assess the crisis nature of the situation and refer the individual to appropriate services.

Conclusion

Health-promotion programming is an emergent field in which sociological practitioners can utilize theoretical, research, and interventionist skills. The application of theoretical initiatives provides one basis for the introduction, testing and revision of health program ideas. Needs assessment, health risk appraisal, health status measurements, and evaluation tools are an integral part of developing and maintaining adequate programming specifically targeted to meet the

needs of employees. The sociological practitioner could be a valuable resource in the development of health promotion programs at the worksite. However, given the uncertainty of medical criteria for "fitness," the prevalence of organizationally and environmentally linked health hazards, the tendency to focus on individual change, and the existence of opportunities for the violation of the employee's rights, the health-promotion field provides some ethical challenges for the practitioner who is willing to get involved.

REFERENCES

Allegrante, John P., and Richard P. Sloan
　　1986　　Ethical dilemmas in workplace health promotion. *Preventive Medicine* 15:313–20.
Attkisson, C. Clifford, William A. Hargreaves, Mardi J. Horowitz, and James E. Sorensen
　　1978　　*Evaluation of Human Service Programs.* New York: Academic Press.
Banks, Michael H.
　　1983　　Validation of the general health questionnaire in a young community sample. *Psychological Medicine* 13:349–53.
Becker, Marshall H.
　　1974　　The health belief model and personal health behavior. *Health Education Monographs* 2:326–473.
Becker, Marshall H., Robert H. Drachman, and John P. Kirscht
　　1974　　A new approach to explaining sick-role behavior in low-income populations. *American Journal of Public Health* 64:205–16.
Becker, Marshall H., Don P. Haefner, Stanislov V. Kasl, John P. Kirscht, Lois A. Maiman, and Ivan M. Rosenstock
　　1977　　Selective psychological models and correlates of individual health-related behaviors. *Medical Care* 15 (Supplement): 27–46.
Becker, Marshall H., Lois A. Maiman, John P. Kirscht, Don P. Haefner, and Robert H. Drachman
　　1977　　The Health Belief Model and Prediction of Dietary Compliance: A Field Experiment, Journal of Health and Social Behavior 18:348–66.
Breslow, Lester, Jonathan Fielding, Anthony Herrman, and Curtis Wilbur
　　1990　　Worksite health promotion: Its evolution and the Johnson and Johnson experience. *Preventive Medicine* 19:13–21.
Castillo-Salgado, Carlos
　　1984　　Promotion of health in the workplace: The relative worth of lifestyle and environmental approaches. *Social Science and Medicine* 19:349–58.
Cheney, George, and P. Tompkins
　　1987　　Coming to terms with organizational identification and commitment. *Central States Speech Journal* 38:1–15.
Conrad, Peter
　　1988　　Worksite health promotion: The social context. *Social Science and Medicine* 25(5):485–89.
Cunningham, Robert M.
　　1982　　*Wellness at Work.* Chicago: Blue Cross Association.

Davis, M. F., K. Rosenberg, D. C. Iverson, T. M. Vernon, and J. Bauer
    1984   Worksite health promotion in Chicago. *Public Health Report* 99:538–43.
Dunn, Halbert L.
    1961   *High Level Wellness.* Arlington, Va.: R. W. Beatty.
Elling, Ray H.
    1986   *The Struggle for Worker's Health: A Study of Six Industrialized Countries.* Farm-
                ingdale, N.Y.: Baywood.
Felix, Michael R., Albert J. Stunkard, Rita Y. Cohen, and Nancy B. Cooley
    1985   Health promotion at the worksite, *Preventive Medicine* 14:99–108.
Fielding, Jonathan E.
    1984   Health promotion and disease prevention at the worksite. *Annual Review of Public
                Health,* 237–65.
Fielding, Jonathan E., and L. Breslow
    1983   Health promotion programs sponsored by California employers. *American Journal
                of Public Health* 73:538–42.
Fielding, Jonathan E., and P. V. Piserchia
    1989   Frequency of worksite health promotion programs. *American Journal of Public
                Health* 79:16–20.
Freedman, Rita
    1986   *Beauty Bound.* Lexington, Mass.: Lexington Books.
Gecas, Viktor
    1982   The self-concept. In R. H. Turner and J.F. Short (eds.), *Annual Review of Sociology*
                8:1–33. Palo Alto, Calif.: Annual Reviews.
Glassner, Barry
    1989   Fitness and the postmodern self. *Health and Social Behavior* 30:180–91.
Glassner, Barry and Jonathan Freedman
    1979   *Clinical Sociology.* New York: Longman.
Goldberg, D. P. and V. F. Hillier
    1979   A scaled version of the General Health Questionnaire. *Psychological Medicine*
                9:139–45.
Goldstein, Michael S., Judith M. Siegel, and Richard Boyer
    1984   Predicting changes in perceived health status. *American Journal of Public Health*
                74:611–14.
Harris, Daniel M., and Sharon Guten
    1979   Health-protective behavior: An exploratory study. *Journal of Health and Social
                Behavior* 20:17–29.
Haynes, Robert B., Don W. Taylor, and Don L. Sackett
    1981   *Compliance in Health Care.* Baltimore: Johns Hopkins University.
Hills, Stuart L.
    1987   *Corporate Violence.* Totowa, N.J.: Rowman and Littlefield.
Hollander, Robert B., and Joseph J. Lengermann
    1988   Corporate characteristics and worksite health promotion programs: Survey findings
                from Fortune 500 companies. *Social Science and Medicine* 26(5):491–501.
Kettner, Peter, J. M. Daly, and A. W. Nichols
    1985   *Initiating Change in Organizations and Communities: A Macro Practice Model.*
                New York: Brooks-Cole.
Kiefhaber, Anne K., and Willis B. Goldbeck
    1986   Worksite wellness. Pp. 67–73 in K. Dychtwald (ed.), *Wellness and Health Promo-
                tion for the Elderly.* Rockville, Md.: Aspen.

Kristein, M.
    1980   How much can business expect to earn smoking cessation? Paper presented at the
                National Interagency Council on Smoking and Health, Chicago.
LaRosa, J. H.
    1983   National Heart, Lung and Blood Institute demonstration projects in workplace high
                blood pressure control. Available from NHLBI, Building 31, Room 4A18, Bethesda,
                MD 20205.
Lovato, Chris Y. and Lawrence W. Green
    1990   Maintaining employee participation in workplace health promotion programs.
                Health Education Quarterly 17:73–88.
McCall, George J., and Jean L. Simmons
    1978   *Identities and Interactions.* New York: The Free Press.
Mead, George H.
    1934   *Mind, Self, and Society.* Chicago: University of Chicago Press.
Minkler, Meredith
    1978   Ethical issues in community organization. *Health Education Monographs* 6:198–
                201.
    1989   Health education, health promotion and the open society: An historical perspective.
                Health Education Quarterly 16(1):17–30.
Mossey, J. M., and E. Shapiro
    1982   Self-rated health: A predictor of mortality among the elderly. *American Journal of
                Public Health* 72:800–8.
Naditch, M. P.
    1984   The Staywell Program. In J. P. Matarezzo (ed.), *Behavioral Health: A Handbook
                of Health Enhancement and Disease Prevention.* New York: John Wiley and Sons.
Nelkin, Dorothy, and Michael S. Brown
    1984   *Workers at Risk: Voices from the Workplace.* Chicago: University of Chicago Press.
Patrick, Donald L., J. W. Bush, and Milton M. Chen
    1973   Methods for measuring levels of well-being for a health status index. *Health Ser-
                vices Research* 8:228–45.
Patton, Robert W., James M. Corry, Larry R. Gettman, and Joleen S. Graf
    1986   *Implementing Health/Fitness Programs.* Chicago: Human Kinetics Publishers.
Rosenstock, Irwin M.
    1966   Why people use health services. *Millbank Memorial Fund Quarterly* 44:94–127.
Sackett, David, Chambers, L.W., MacPherson, A.S., Goldsmith, C.H., and Mcauley, R.G.
    1977   The development and application of indices of health: General methods and a
                summary of results. *American Journal of Public Method* 67:423–28.
Sallis, James F., William L. Haskell, Stephen P. Fortmann, Karen M. Vranizan, C. Barr Taylor, and
Douglas S. Solomon
    1986   Predictors of adoption and maintenance of physical activity in a community sample.
                Preventive Medicine 15:331–41. Singer, E., R. Garfinkel, S. M. Cohen, et al.
    1976   Mortality and mental health: Evidence from the Midtown Manhattan Restudy. *So-
                cial Science and Medicine* 10:517–25.
Smith, Kevin W., Sonja M. McKinlay, and Bruce, D. Thorington
    1987   The validity of health risk appraisal instruments for assessing coronary heart disease
                risk. *American Journal of Public Health* 77:419–24.
Stockel, Leslie
    1988   Employment relations programs. *Employment Relations Today* 15:351–57.

Stryker, Sheldon
    1968   Identity salience and role performance: The relevance of symbolic interaction the-
                ory for family research. *Journal of Marriage and the Family* 30:558–64.
Suchman, Edward
    1964   Sociomedical variations among ethnic groups. *American Journal of Sociology*
                70:319–31.
    1967   *Evaluative Research.* New York: Russell Sage.
Thomas, William I.
    1931   *The Unadjusted Girl.* Boston: Little, Brown & Co.
Turner, Jonathan H.
    1987   Toward a sociological theory of motivation. *American Sociological Review*
                52:15–27.
Weis, R. C.
    1981   Can you afford to hire smokers? *Personnel Administrator* 26:71–80.
World Health Organization
    1948   Constitution of the World Health Organization. In World Health Organization Basic
                Documents.

Obesity and Nutritional Sociology: A Model for Coping with the Stigma of Obesity

Jeffery Sobal
Division of Nutritional Sciences, Cornell University

ABSTRACT

Nutritional sociology uses sociological theories and methods to study and influence food patterns, eating habits, and nutrition. Obesity and weight loss are important topics in nutritional sociology, and stigmatization of the obese is a long-standing interest. Most past sociological work has only described stigmatization, rather than developing ways to facilitate coping with it. A model for coping with the stigma of obesity is presented here. The model includes four components: Recognition, Readiness, Reaction, and Repair. Recognition involves awareness of the stigma of obesity and understanding about stigmatization. Readiness involves anticipation that stigmatization may occur in specific settings or by some people, and preparation for and prevention of stigmatizing acts. Reaction involves immediate and long-term coping techniques to deal with a stigmatizing act. Repair involves the recovery from stigmatization and attempts at restitution and reform of the stigmatizing actions of others. This model uses a sociological perspective to develop strategies for dealing with stigmatization, which differs from a medical model for dealing with obesity. This sociological model for helping people cope with the stigma of obesity may also be useful with other types of stigmas.

Nutritional sociology is the application of sociological theories and methods to study and influence food patterns, eating habits, and nutrition. Obesity is an important topic within nutritional sociology, with considerable attention

being paid to overweight and weight loss by sociologists. Examples include examination of patterns of obesity according to socioeconomic status or marital status (Sobal, 1984a; Sobal and Stunkard, 1989), investigation of foods seen as "diet" or fattening (Sobal and Cassidy, 1987, 1990), and the study of weight loss groups and organizations (Allon, 1973a, 1975, 1979a; Laslett and Warren, 1975; Millman, 1980; Sussman, 1956a, 1956b). Using the distinction developed by Straus (1957), little sociological work on obesity involves the applied practice of sociology *in* nutrition, as compared to the academic study of the sociology *of* nutrition (Murcott, 1983, 1988).

Stigmatization of the obese is a long-standing interest of sociologists. Most past sociological work on the topic has only described stigmatization, rather than developed ways to assist in coping with stigmatization. Sociological work on obesity and stigmatization has much unrealized potential applicability for sociological practice. This paper will review existing knowledge about the stigmatization of obesity, and will then present a four-component model that can be used to assist people in coping with the stigma of obesity.

The concept of stigmatization was developed by Goffman (1963) to describe negative reactions to many conditions, including obesity, mental illness, cancer, AIDS, disabilities, etc. The concept has received extremely wide attention in the social and health sciences. Despite the wide appreciation of the insightfulness of the idea, the concept of stigma has primarily been applied only to the extent of recognizing that a condition is stigmatized. Little further elaboration of specific techniques for coping with stigmatization or ways of assisting others in coping with their stigmatization has been developed. Theoretical work on stigmatization can be clinically applied to stigmatized conditions by sociological practitioners to assist others in overcoming and coping with it.

Sociology is very good at defining, describing and disseminating insightful and powerful concepts such as stigma, but has largely left the development of ways to deal with these issues to other applied disciplines such as clinical psychology, social work, nursing and medicine. Work on stigmatization by anthropologists (Ablon, 1981) and psychologists (Ainlay, Becker, and Coleman, 1986; Herman, Zanna and Higgins, 1986; Jones, Farina, Hastorf, Markus, Miller and Scott, 1984) has not gone much beyond the efforts of sociologists in developing models for applying knowledge about stigmas. The growing areas of clinical sociology and applied sociological practice can fill that gap.

A stigma is usually like the weather: everybody is talking about it but nobody is doing anything about it. Many sociologists have described the concept of stigma and how, when, where and to whom it applies, but have put little effort into helping stigmatized individuals cope with stigmatization and present little guidance for people helping others to deal with it. Description exists for how

victims of various types of stigmatization manage their stigmas (Beuf, 1990; Boutte, 1987; Gramling and Forsyth, 1987; Gussow and Tracy, 1968; Hilbert, 1984; Schneider and Conrad, 1983; Wahl and Harman, 1989; Weitz, 1990), including methods of concealing or selectively revealing stigmas, denial, withdrawal, intellectualization, anger, changing social networks, enhancing social support, gathering factual information, educating those who stigmatize, acting with bravado, and developing militancy. However, such activities remain largely descriptive, with some exceptions (Beuf, 1990), and make little effort in applying these coping techniques to actually help people cope with stigmatization.

The Stigmatization of Obesity

Obesity is defined as an "excess" of body fat, although any cutoff distinguishing obese and nonobese individuals is purely arbitrary because body fat is distributed in a continuum similarly to other physical characteristics in populations such as height (Sobal and Muncie, 1990). There is a consensus in the medical community that obesity is associated with a variety of health risks, and most health professionals believe that their patients should not become obese and that those who are obese should lose weight (Sobal and Muncie, 1990).

In addition to the medical problems associated with obesity, there is severe negative evaluation of obesity in modern Western societies, particularly the United States. Social values about obesity in modern societies are generally negative, contrasting with the positive evaluations of fatness in most cultures (Brown and Konner, 1987). Ritenbaugh (1982) suggests that obesity is a culture-bound syndrome that is only seen as a problem in modern, Westernized societies. The social and psychological problems associated with obesity may be as great as physiological maladies (Sobal and Muncie, 1990).

Most work on obesity has used the medical model, which assumes that the problem lies in the obese individual and weight loss is the solution. By contrast, a sociological model may reframe the issue by assuming that the problem of obesity may lie in societal reaction to obese individuals and that solutions other than weight loss may be useful. These two models may function together in some cases and be complementary, while at other times they may conflict.

The stigmatization of obesity in both children and adults has been frequently described during recent decades (Allon, 1973b, 1979b, 1981; Cahnman, 1968; DeJong, 1980; Goodman, Dornbusch, Richardson, and Hastorf, 1963; Hiller, 1981; Jarvie, Lahey, Graziano, and Framer, 1983; Kalisch, 1972; Laslett and Warren, 1975; Richardson, Goodman, Hastorf and Dornbusch, 1961; Siegelman, Miller and Whitworth, 1986; Sobal, 1984b; Tobias and Gordon, 1980; Weiner, Perry and Magnusson, 1988). Beyond stigmatization, discrimination against the

obese has been documented in access to college education (Canning and Mayer, 1966), employment (Harris, Harris and Bochner, 1982; Larkin and Pines, 1979; Matusewitch, 1983; Benson, et al, 1980), earnings (McClean and Moon, 1980), job promotions (Hinkle, et al, 1968) and housing (Karris, 1977). Weight discrimination is emerging as an issue of sufficient importance to be discussed in the legal literature (Baker, 1984). Physicians (Maddox, Bach and Liederman, 1968; Maddox and Liederman, 1969; Maiman, et al, 1979; Najman and Monro, 1982; Price, et al, 1987), as well as medical students (Blumberg and Mellis, 1985), medical residents (Brotman, Stern and Herzog, 1984), and rehabilitation counselors (Kaplan, 1982; Kaplan and Thomas, 1981) have negative attitudes toward the obese. Stigmatization of obesity appears to be pervasive and frequently denies obese individuals access to social roles and various opportunities.

Stigmatization of obesity can be dealt with on two levels: psychological and sociological. Psychologically, specific individuals are stigmatized and the unit of analysis is the person. Obese individuals can be assisted in coping with stigmatization using one-on-one counseling or small group discussions. Sociologically, institutions and social processes promote and enhance stigmatization of the obese and the unit of intervention becomes a collective one. Here, interventions can deal with organizations or provide broad education and attitude change interventions. Dealing with stigmatization on both levels is important.

Considering the issue of obesity requires a differentiation among stigmas, stigmatization, and stigmatizing acts. Stigmas are qualities, attributes or characteristics that may receive negative evaluations from others. Stigmatization is the negative reaction by others to a specific stigma. Thus, a stigma is the negatively valued condition, while stigmatization is the interaction process of someone responding negatively to that condition. Stigmatizing acts are specific negative behaviors or communications involved in stigmatizing actions or events. The example here will be obesity, although a wide variety of conditions exist as stigmas (Goffman, 1963; Jones, et al, 1984; Weiner, Perry, and Magnusson, 1988). While stigmas vary, the process of stigmatization and stigmatizing acts share many commonalities across specific stigmas. With these commonalities in mind, a model for coping with the stigma of obesity will be described which may be generalizable to other stigmatized traits.

A Model for Coping with Stigmatization

A four component-model for coping with stigmatization will be described here for dealing with obesity. The components include (1) Recognition, (2) Readiness, (3) Reaction, and (4) Repair, combining to form an integrated model (Table 1). This model was developed through observation and work in medical

settings; teaching medical students, physicians and nutritionists about obesity and stigmatization; work with obesity and obese people in practice and research; and examining the literature on stigmas.

Table 1.
A Four-Component Model for Coping with Stigmatization of Obesity

1. Recognition
   - Development of awareness that obesity is stigmatized
   - Gaining insight, information, and understanding about stigma
2. Readiness
   - Anticipating settings and people involved in stigmatization
   - Preparation for stigmatizing acts
   - Prevention of stigmatization by information/exposure control
3. Reaction
   - Immediate coping with stigmatizing acts
   - Longer term coping with stigmatizing acts
4. Repair
   - Repair of problems from stigmatizing acts
   - Recovery from problems resulting from stigmatization
   - Restitution and compensation from stigmatization
   - Reform of stigmatizing actions and values of others

Recognition

The most basic component is recognition of stigmatization, which involves awareness that obesity is a stigmatizable condition and that an obese person may be a target of stigmatizing acts. Recognition involves insight and understanding that obese people are vulnerable to stigmatization, and information and knowledge about the extent and type of stigmatization that may occur. Sociologists have written about stigmatization in the professional literature, but this only led to recognition of the issue among other social scientists. Relatively little sociological attention has been given to describing stigmatization to individuals who are stigmatized, educating the public about stigmatization, or helping professionals who deal with people with stigmas.

Presenting the concepts of stigma and stigmatization of obesity can be done by making parallels with other stigmatized conditions, providing insight and similar examples for clients. Discussing stigmatization of AIDS patients, who carry one of the greatest stigmas of any group in society (Herek and Glunt, 1988), can be used to demonstrate the concept of stigma. Giving examples of

other types of stigmas shows how the U.S culture focuses on normalcy and is often unaccepting of deviation from the norm. Discussing stigmatization of other conditions also shows how obesity may be similar to and different from other states, which assists in putting the problem into perspective. Obesity is a physical stigma that is fairly easily observed despite the use of clothing or other means to hide or minimize fatness. By contrast, stigmas such as AIDS or schizophrenia may be concealable and only selectively (or inadvertently) revealed. Recognizing that stigmas may or may not be selectively visible is a key insight for obese people who desire to modify or control display of their stigma.

A problem in recognition is avoiding denial about stigmatization. For example, one obese patient in a medical clinic was aware that she was sometimes stigmatized because of her race, but at first was unwilling to consider the possibility that her weight could be treated similarly. After some discussion she saw that thinking about her weight in the same way she thought about her ethnic background could provide insights into dealing with how others treated her weight.

Recognition of the existence of stigmatization of obesity involves awareness that people are vulnerable to labeling because of their weight. Such labeling may vary in extent based on the level of obesity of the person, as well as varying in intensity of stigmatization by actions of others. Helping people recognize that stigmas exist and are not uniform provides them with information and insight into stigmatization. It operates as a first step in dealing with stigmas by raising consciousness about stigmatization.

Readiness

To effectively cope with stigmatization, a person must anticipate situations and incidents where stigmatization may occur and be ready to deal with them. Such preparation is a key step in coping with stigmatization, permitting obese people to be proactive rather than reactive in potentially stigmatizing interactions. Preparation can involve cognitive or actual rehearsal of stigmatizing events. An obese person can practice reactions to deal with various stigmatizing acts, whether they are verbal, nonverbal, intentional, etc. This type of role play can be highly useful preparation for stigmatization.

Anticipatory guidance about facing stigma can be provided. This can help an obese person move beyond simply recognizing they may face problems in the way others deal with their weight into developing strategies to deal with these problems. A review of past stigmatizing acts involving a particular person

can be used as a basis for developing ways of dealing with similar events in the future.

Sources of stigmatization may be differentiated and different preparations made for various types. Beuf (1990) groups potentially stigmatizing sources into four categories: total strangers, acquaintances and peers, close friends and family members, and professionals. Readiness for different types and amounts of stigmatization from each of these sources needs to be anticipated by obese people, along with the preparation important for the range of stigmatizing acts from staring to verbal ridicule.

Readiness can occur both for the obese person, who may be a victim of stigmatizing acts, and also for the obese person's spouse, friends, or others who may be present and capable of providing assistance. Knowing that sympathetic and supportive others are aware of stigmatization and can assist the obese person during a stigmatizing act provides important social support for a person during a time of stress. Organizations and institutions have developed policies prohibiting weight discrimination which provide readiness for dealing with instances of stigmatization as they occur.

An important part of readiness is knowledge about the stigma to which others are reacting. The more a person understands about his or her own obesity, including nutritional and medical information, the more that person is ready to react to any negative responses of others. Relevant factual information and research findings are useful in dealing with other types of stigmas (Wahl and Harmon, 1989), and the same is true of obesity.

Prevention of a stigmatizing act can occur with proper readiness. This can be accomplished through information control, where a person can hide or minimize the awareness other people have of obesity or by making obesity less salient during an interaction. For example, advice about how to dress to look thinner can be useful for some people. A problem in such prevention is that it accepts the deviant labeling of obesity, which can have emotional and social costs for the obese person. Readiness is also accomplished through control of exposure both of a person's own obesity, as in carefully selecting settings where fatness may become an issue, such as recreation events or the beach, to avoid situations where they may be discredited for their obesity. Also, exposure to individuals who may be likely to stigmatize an obese person may need to be monitored, controlled or limited, particularly exposure to people who previously stigmatized obese people.

Readiness for stigmatization requires developing skill in contingency management, which permits planning ahead for potentially stigmatizing events. Obese people who may be stigmatized need to know what to anticipate in order

to cope with or avoid stigmatization and to minimize negative consequences. These skills provide empowerment for obese people who may be stigmatized.

Reaction

Stigmatizing acts may range from short verbal comments to major long-term events that involve severe discrimination or exclusion from important social opportunities or positions. Successful coping with such stigmatization should include a planned reaction that permits an obese person to deal with the stigmatizing event immediately and also to react in a longer-term manner.

Immediate coping with a stigmatizing action needs to be based on the capabilities and personal resources an individual has developed as a part of the readiness component of this model. Beuf (1990) developed a framework for assessing children's ability to cope with stigmatization that considers age, competency, physiological resources, psychological resources, social resources, and levels of interaction. Those who work with obese people who are stigmatized may find it useful to assess these categories in their clients. Reactions use these to diffuse tension, such as the shifting of mean-spirited comments about obesity into another frame of reference by using humor. Immediate coping with stigmatizing acts may shift the focus of the interaction away from obesity as the issue being stigmatized, in order to prevent psychological and social damage to the obese person. For example, many stigmatizing acts directed at obese individuals involve comments about the predicaments they face because of their size. Reactions to such comments can range from demonstrations that the predicament is untrue to retorts that reframe the comment in a positive light. Awareness of the common comments and metaphors used in stigmatization and discrimination against obese people can be used to develop reaction strategies and contingency strategies if immediate reactions fail.

Reactions that redeem the stigmatized person need to be prepared, including various rationale for extricating the obese person from further stigmatization. This could involve the use of medical, rather than moral, perspectives about obesity to shift the frame of reference. The definition of the situation stigmatizing obesity as badness (a moral attack on the victim as being lazy, without will power, etc.), can be shifted to the definition of obesity as an illness (a medical response potentially attributable to genetics, endocrinology, etc.), which uses the exemption of blame implied in the sick role to minimize stigmatization. However, this particular strategy is not without some costs. It continues to accept the social definition of obesity as deviant and only shifts the explanation for the deviance.

Collective reactions to the stigmatization of obesity also can be developed for organizations and institutions. These can include encouragement of group norms and attitudes that promote weight acceptance and do not tolerate stigmatization and discrimination against the obese. Sometimes this can involve written policies of the organization, such as in hiring policies, although it may only require discussion and statement of values that are weight tolerant.

After immediate reaction to a stigmatizing event, longer-term reaction may also be important. This may involve extended reactions to the person or group stigmatizing an obese individual, which may be part of the same social interaction or contacts at later points in time. Longer-term reactions may be more measured, with more opportunity to change attitudes and practices of people who stigmatize the obese. Having a strategy for dealing with longer term reactions and thinking ahead about how reactions might be dealt with make them more important than immediate and transitory reactions. For example, it is more important for an obese person to have strategies to react to persistent stigmatization by coworkers than a random comment by a stranger at the beach.

Plans for longer-term reaction will vary, but certainly will include the development of empathy among individuals who stigmatize the obese, based on having them appreciate the obese person by developing the ability to assume the role of someone who is obese. Open and frank talk about obesity is often a useful reaction, demonstrating to the person doing the stigmatizing that obesity is not a taboo topic and that others can understand and appreciate the life of someone who is obese. Poignant literature may help demonstrate these issues to others (Millman, 1980; Stunkard, 1976).

Repair

After reacting to a stigmatizing event, a complete coping process should include repair of any problems that occurred from that specific stigmatizing act, recovery from these problems, and also reform of the conditions that led to the stigmatization. Social support can be sought by obese individuals who have been stigmatized in the usual forms (families, friends, neighbors, or organizations) plus those specific to obesity as a stigmatized condition (other dieters or associations of obese individuals).

Even if a person was ready for a stigmatizing event and reacted fairly well, they must recover from the fundamentally negative stigmatizing experience. This includes immediate restoration as well as adjustments for the future. The blow to an obese person's self-esteem from verbal comments or discriminatory acts requires entry into a psychological healing process. This can be short and personal or longer and involve others. Social support may be sought from an

empathetic partner or a group of other obese people. Allon (1975) describes how dieting groups provide the opportunity for obese people to share experiences and provide support for one another.

Repair can also involve personal adjustments for future stigmatization. This feeds back into the earlier components of this model for coping with stigmatization. Repair involves new recognition of stigmas by learning from each experience, increasing readiness for similar types of stigmatization in the future, and permitting the current reactions to be assessed and modified.

Repair occurs beyond individual adaptation. This may involve seeking restitution from people committing stigmatizing acts, and reform of people and conditions that were involved in stigmatization. These components of coping with the stigmatization of obesity go beyond specific events to larger social reforms that may prevent future stigmatization.

Restitution may be sought from individuals or collectivities that stigmatize obese people. This can involve seeking compensation through interpersonal or even legal means for damages that occurred as a result of stigmatization. A growing number of legal cases waged for victims of weight discrimination (Baker, 1984) have been decided predominantly in favor of the obese person.

Reform is the part of repair that seeks individual and societal change to lead to less stigmatization and discrimination against the obese. Individuals may be reformed by an obese person or others who recognize the problems inherent in stigmatization. This can occur through the development of empathy and provision of data about obesity using any of a number of approaches that change attitudes and values. Organizations, groups, institutions, and other collective bodies can be formally changed through legal means, policy statements, and other means, and their informal values and attitudes can be changed through discussions and presentations. A fat rights/fat pride movement has developed which has worked toward social reform about weight in society (Grossworth, 1971; Louderback, 1970; Orbach, 1984). Sociologists may assist some individuals in coping with the stigma of obesity by directing them to literature and organizations in this area. Sociologists also may make contributions to reform the stigmatization of obesity at larger levels by doing research, changing opinions and practices of influential people who deal with obese individuals, conducting classroom and public education to change sociel values, and other activities that reform social values about obesity.

Many stigmatized groups have developed organizations that attempt to overcome the stigmatization of their condition by empowering their members, fostering social change in attitudes about the stigmatized condition, and working for legal reform with respect to their problem. Obesity is no exception. Several support and reform groups exist, including the National Association to Aid Fat

Americans, Ample Opportunity, Diet/Weight Liberation, and others. Sociologists have been involved in these organizations and have contributed to their meetings and activities.

Implications

Nutritional sociologists can assist people in dealing with stigmatized conditions using a model that provides guidance in coping with stigmas. Roles that clinical sociologists have played in dealing with the stigma of obesity include counselors of individuals and families, consultants to health professionals, expert witnesses at hearings and trials, analysts in organizations, advocates of groups, societal analysts, program evaluators, educators, and documenters of the stigma associated with obesity. This diversity of activities shows the potential roles for sociologists in this area, and use of a model to frame these activities should encourage more and improved work with stigmatization in the future.

The model presented here can be applied by sociologists working on many levels. Obese people can be assisted in coping with stigmatization by working with them, and by using individual or group counseling. The stigma of an individual may extend to social units in which the person is a member, such as families (Wahl and Harmon, 1989), and the model presented here also can be used to help people stigmatized from their association with obese people cope with stigmatization. Organizations and institutions can also be guided using this model.

Clinical work on stigmatization can usefully draw on distinctions made by medical and public health practitioners among three types of prevention: primary, secondary, and tertiary. Primary prevention involves avoiding the occurrence of a problem. For the stigmatization of obesity, this could involve avoiding stigmatization by recognizing people, occasions, or settings where stigmatization is likely to occur. Secondary prevention involves identifying a problem at an early stage and intervening to change the typical negative course of the problem. For the stigmatization of obesity, this could involve being ready for stigmatization, reacting quickly, and having repair strategies mapped out. Tertiary prevention involves not letting a problem that has occurred lead to severe and long-term outcomes. For the stigmatization of obesity, this might mean the use of restoration and recovery measures to repair the consequences of stigmatizing actions by others. These examples show how the model proposed here is compatible with and can be translated into perspectives understood and used in the health professions. Sociologists who work with health professionals need to be able to mediate between sociological and medical concepts.

Applying a sociological perspective to the stigma of obesity can restructure the issue by showing that the problem is not only a physical issue based on the stigmatized characteristic, but also is a social problem that can be dealt with using insights and interventions from sociology. The predominant medical perspective for dealing with obesity focuses on changing the stigma by losing weight. Psychologists have largely allied themselves with the medical model by developing psychological methods to modify eating behaviors that assist people in losing weight. The orientation of psychologists dealing with obesity has been more as behavioral scientists than social scientists.

Sociologists can shift the frame of reference from changing stigmas to changing stigmatization. Their real contribution to working with obese people lies in analysis of the interpersonal and social aspects of obesity and assisting obese people in dealing with these issues. This does not negate the potential for sociological contributions to weight loss efforts, but rather points out a more unique social science contribution they can make in their practice with obese people.

Practical tools that may be useful in helping people use this four-component model include memory aids and handouts. The model presented here can be easily remembered using a "four R" mnemonic for the names of each of the components. Another potential tool is using a person's hand as a memory aid, with the thumb representing stigmas that can be opposed by touching it with each finger which represents one of the four components of the model. Finally, a straightforward table or card handout can be developed such as the one presented in Table 2. This uses direct statements that are guides to enacting each of the four components of the model.

Table 2.
A Client Handout for a Model to Cope with Stigma

1. Recognize the problem of stigma
   - Be aware that stigmatization exists
   - Understand how it may affect you
2. Ready yourself for stigmatizing situations
   - Anticipate where you may be stigmatized
   - Prepare yourself for potential stigmatization
3. React appropriately to stigmatization
   - Deal with stigmatization
   - Minimize any problems stigmatization may cause
4. Repair any problems stigmatizing may cause
   - Heal yourself from any problems and injuries
   - Work to prevent future stigmatization

The model presented here could also be used for other stigmatized conditions ranging from AIDS to various disabilities. Application to other conditions would need modification, but the basic framework and many specific strategies may be directly transferable. Information gleaned from other applications may be useful in modifying the model to make it more useful for application to obesity.

Sociological practice includes many opportunities for involvement with obesity and other stigmatized conditions. The extensive weight-loss industry and strong cultural emphasis on nutrition demonstrate interest in the topic. Sociologists can apply their unique theoretical perspectives to make contributions that help people deal with obesity and other stigmas, and should increase their efforts in that area.

REFERENCES

Ablon, J.
  1981   Stigmatized health conditions. *Social Science and Medicine* 15b:5–9.
Ainlay, S. C., G. Becker, and L. M. Coleman
  1986   *The Dilemma of Difference: A Multidisciplinary View of Stigma.* New York: Plenum.
Allon, N.
  1973a   Group dieting rituals. *Transaction/Society* 10(2):36–42.
  1973b   The stigma of overweight in everyday life. Pp. 83–102 in G. A. Bray (ed.), *Obesity in Perspective.* Fogarty International Series in Preventive Medicine, 2, Part 2. Washington, D.C.: U.S. Government Printing Office.
  1975   Latent social services in group dieting. *Social Problems* 23(1):56–69.
  1979a   Group dieting. Pp. 29–81 in N. Allon (ed.), *Urban Lifestyles.* Dubuque, Iowa: William. C. Brown.
  1979b   Self perceptions of the stigma of overweight in relationship to weight losing patterns. *American Journal of Clinical Nutrition* 32:470–80.
  1981   The stigma of overweight in everyday life. Pp. 130–74 in B. J. Wolman (ed.), *Psychological Aspects of Obesity: A Handbook.* New York: Van Nostrand Reinhold Company.
Baker, J.
  1984   The Rehabilitation Act of 1973: Protection for victims of weight discrimination? *UCLA Law Review* 29:947–71.
Benson, P. L., D. Severs, J. Tatgenhorst, and N. Loddengaard
  1980   The social costs of obesity: A non-reactive field study. *Social Behavior and Personality* 8(1):91–96.
Beuf, A. H.
  1990   *Beauty Is the Beast: Appearance-Impaired Children in America.* Philadelphia: University of Pennsylvania Press, 1990.

Blumberg, P., and L. P. Mellis
    1985   Medical students' attitudes towards the obese and morbidly obese. *International Journal of Eating Disorders* 4(2):169–75.
Boutte, M. I.
    1987   The stumbling disease: A case study of stigma among Azorean-Portuguese. *Social Science and Medicine* 24:209–17.
Brotman, A. W., T. A. Stern, and D. B. Herzog
    1984   Emotional reactions of house officers to patients with anorexia nervosa, diabetes, and obesity. *International Journal of Eating Disorders* 3(4):71–77.
Brown, P. J., and M. Konner
    1987   An anthropological perspective on obesity. *Annals of the New York Academy of Sciences* 499:29–46.
Cahnman, W. J.
    1968   The stigma of obesity. *Sociological Quarterly* 9:283–99.
Canning, H., and Mayer, J.
    1966   Obesity—Its possible effect on college acceptance. *New England Journal of Medicine* 275:1172–74.
DeJong, W.
    1980   The stigma of obesity: Consequences of naive assumptions concerning the causes of physical deviance. *Journal of Health and Social Behavior* 21:75–87.
Goffman, E.
    1963   *Stigma: Notes on the Management of Spoiled Identity.* Englewood Cliffs, N.J.: Prentice Hall.
Goodman, N., S. M. Dornbusch, S. A. Richardson, and A. H. Hastorf
    1963   Variant reactions to physical disabilities. *American Sociological Review* 28:429–35.
Gramling, R. and J. C. Forsyth
    1987   Exploiting stigma. *Sociological Forum* 2:401–15.
Grossworth, M.
    1971   *Fat Pride.* New York: Jarrow Press.
Gussow, Z., and G. S. Tracy
    1968   Status, ideology, and adaptation to stigmatized illness: A study of leprosy. *Human Organization* 27:316–25.
Harris, M. B., B. J. Harris, and S. Bochner
    1982   Fat, four-eyed, and female: Stereotypes of obesity, glasses, and gender. *Journal of Applied Social Psychology* 12:503–16.
Herek, G. M., and E. K. Glunt
    1988   An epidemic of stigma: Public reactions to AIDS. *American Psychologist* 43:886–91.
Herman, C. P., M. P. Zanna, and E. T. Higgins
    1986   *Physical Appearance, Stigma and Social Behavior.* Hillsdale, N.J.: Lawrence Earlbaum.
Hilbert, R. A.
    1984   The acural dimensions of chronic pain: Flawed reality construction and the problem of meaning. *Social Problems* 31:365–78.
Hiller, D. V.
    1981   The salience of overweight in personality characterization. *Journal of Personality* 108:233–40.

Hinkle, L. E., L. H. Whitney, E. W. Lehman, J. Dunn, B. Benjamin, R. King, A. Plakun, and
        B. Flehinger
    1968   Occupation, education, and coronary heart disease. *Science* 161:238–46.
Jarvie, G. J., B. Lahey, W. Graziano, and E. Framer
    1983   Childhood obesity and social stigma: What we do and what we don't know. *Developmental Review* 3:237–73.
Jones, E. F., A. Farina, A. H. Hastorf, H. Markus, D. T. Miller, and R. A. Scott
    1984   *Social Stigma: The Psychology of Marked Relationships.* New York: W. Freeman.
Kalisch, B. J.
    1972   The stigma of obesity. *American Journal of Nursing* 72:1124–27.
Kaplan, S. P.
    1982   Attitudes of professionals toward the obese. *Obesity and Bariatric Medicine* 11(2):32–33.
Kaplan, S. P., and K. Thomas
    1981   Rehabilitation counseling students perceptions of obese clients. *Rehabilitation Counseling Bulletin* 25:106.
Karris, L.
    1977   Prejudice against obese renters. *Journal of Social Psychology* 101:159–60.
Larkin, J. C., and H. A. Pines
    1979   No fat persons need apply: Experimental studies of the overweight stereotype and hiring preference. *Sociology of Work and Occupations* 13:379–85.
Laslett, B., and C.A.B. Warren
    1975   Losing weight: The organizational promotion of behavior change. *Social Problems* 23:69.
Louderback, L.
    1970   *Fat Power.* New York: Hawthorne Books.
Maddox, G. L., K. Back, and V. Liderman
    1968   Overweight as social deviance and disability. *Journal of Health and Social Behavior* 9:287–98.
Maddox, G. L., and V. Liederman
    1969   Overweight as a social disability with medical complications. *Journal of Medical Education* 44:214–20.
Maiman, L. A., V. L. Wang, M. H. Becker, J. Finlay, and M. Simonson
    1979   Attitudes toward obesity and the obese among professionals. *Journal of the American Dietetic Association* 74:331–36.
Matusewitch, E.
    1983   Employment discrimination against the overweight. *Personnel Journal* 62:446–50.
McClean, R. A., and M. Moon
    1980   Health, obesity and earnings. *American Journal of Public Health* 70(9):1006–9.
Millman, M.
    1980   *Such a Pretty Face: Being Fat in America.* New York: W. W. Norton.
Murcott, A. (ed.)
    1983   *The Sociology of Food and Eating.* Hants, England: Glower House.
Murcott, A.
    1988   Sociological and social anthropological approaches to food and eating. *World Review of Nutrition and Dietetics* 55:1–40.
Najman, J.M., and C. Monroe
    1982   Patient characteristics negatively stereotyped by doctors. *Social Science and Medicine* 16:1781–89.

Orbach, S.
    1984   *Fat is a Feminist Issue.* London: Hamlyn.
Price, J. H., S. M. Desmond, R. A. Krol, F. F. Snyder, and J. K. O'Connell
    1987   Family practice physicians' beliefs, attitudes and practices regarding obesity. *American Journal of Preventive Medicine* 3(6):339–45.
Richardson, S. A., N. Goodman, A. H. Hastorf, and S. M. Dornbusch
    1961   Cultural uniformity in reaction to physical disabilities. *American Sociological Review* 26:241–47.
Ritenbaugh, C.
    1982   Obesity as a culture-bound syndrome. *Culture, Medicine and Psychiatry* 6:347–61.
Siegelman, C. K., T. E. Miller, and L. A. Whitworth
    1986   The early development of stigmatizing reactions to physical differences. *Journal of Applied Developmental Psychology* 7:17–32.
Schneider, J. and P. Contrad
    1983   *Having Epilepsy.* Philadelphia: Temple University Press.
Sobal, J.
    1984a   Group dieting, the stigma of obesity, and overweight adolescents: Contributions of Natalie Allon to the sociology of obesity. *Marriage and Family Review* 7(1/2):9–20.
    1984b   Marriage, obesity and dieting. *Marriage and Family Review* 7(1/2):115–40.
Sobal, J., and C. Cassidy
    1987   Dieting foods: Conceptualizations and explanations. *Ecology of Food and Nutrition* 20(2):89–96.
    1990   University students' perceptions of fattening and dieting foods in relationship to the four food groups. *Nutrition Research* 10:145–54.
Sobal, J., and H. L. Muncie
    1990   Obesity. Pp. 1241–49 in R. E. Rakel (ed.), *Textbook of Family Practice.* Philadelphia: W. B. Saunders Co.
Sobal, J., and A. J. Stunkard
    1990   Socioeconomic status and obesity: A review of the literature. *Psychological Bulletin* 105(2):260–75.
Straus, Robert
    1957   The nature and status of medical sociology. *American Sociological Review* 22:200–4.
Stunkard, A.J.
    1976   *The Pain of Obesity.* Palo Alto, Calif: Bull Publishing Company.
Sussman, M. B.
    1956a   Psycho-social correlates of obesity: Failure of the calorie collectors. *Journal of the American Dietetic Association* 32:423–28.
Sussman, M. B.
    1956b   The calorie collectors: A study of spontaneous group formation, collapse and reconstruction. *Social Forces* 34:351–56.
Tobias, A. L., and J. B. Gordon
    1980   Social consequences of obesity. *Journal of the American Diabetic Association* 76:338–42.
Wahl, O. F., and C. R. Harmon
    1989   Family views of stigma. *Schizophrenia Bulletin* 15:131–39.

Weiner, B., Perry, R. P., and Magnusson, J.
    1988   An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology* 55:738–48.
Weitz, R.
    1990   Living with the stigma of AIDS. *Qualitative Sociology* 13:23–38.

Developing New Models of Service Delivery to Aged Abuse Victims: Does It Matter?

Mary C. Sengstock
Wayne State University
Melanie Hwalek
Michigan State University/Wayne State University
Carolyn Stahl
State of Illinois Department on Aging

ABSTRACT

The political pressures imposed on social agencies often require the introduction of alternative models of service delivery. There is some question, however, as to the effectiveness of such theoretical models. Do they play an important role in determining the types of services provided, their effectiveness, or the manner in which the agencies provide the services? Or do agencies provide relatively similar services, regardless of the model? This paper provides an analysis of the services provided to elderly victims of abuse under two different theoretical models: a legal model (with two variations), and a model of intensive service delivery. The programs also varied by region, with two in rural and two in suburban areas. The study was supported by the Illinois Department on Aging, with data collected on 204 elder abuse cases seen during calendar year 1986. Abuse types included Physical Abuse, Confinement, Sexual Abuse, Deprivation, Neglect, Self Neglect, and Financial Exploitation. Results revealed no differences between the models in the services provided or the outcome of cases. Suggestions are made as to the reasons for this finding and the other factors that may have played greater roles.

Statement of Problem

Abuse and neglect of older adults is a problem that has received increasing attention in recent years, from the earliest studies which focused on abuse cases observed by medical and social service agencies (Block and Sinnott, 1979; Hickey and Douglass, 1981; Sengstock and Liang, 1983), to recent attempts to gauge the incidence of abuse in the aged population (Pillemer and Finkelhor, 1988). Research has suggested the value of certain types of services in resolving elder abuse problems, including in-home social work (Kinderknecht, 1986); legal assistance (Sengstock and Barrett, 1986); inpatient psychiatric services (Lau, 1986); and crisis intervention, counseling, and support services for both victim and family (Kinney et al., 1986). However, no published literature exists on the models under which these services are delivered.

It has also been noted that each elderly abuse victim usually requires a wide variety of services, and that these should be integrated into a comprehensive, unified whole (Wolf et al., 1985–1986; Conley, 1986). However, needed services are not always available. Funding mechanisms often exclude certain types of services, and many services are unavailable in some communities (Kinderknecht, 1986). Service provision is also complicated by agency fragmentation (Emlet, 1984), and many service providers lack training or experience in dealing with elder abuse, having been trained prior to the recognition of this problem. This is a special difficulty for new workers or for those who handle only an occasional case of elder abuse.

In an attempt to improve services for abused and neglected elders and provide guidance to workers, some social and governmental agencies have developed new theoretical models for the delivery of services to the elders and their families (Traxler, 1986). Such theoretical models are based on the assumption that the design of the program can play an important role in the delivery of services to clients. The value of such theoretical service models is not entirely clear, however. In some instances, new service models have resulted in improved services (Emlet, 1984). In others, the initial promise of a new service model has not been borne out over time (Kallen, 1984).

When such models are developed, sociologists and psychologists are frequently asked to serve as consultants, to assist in evaluating the effectiveness of the models being tested. This paper is an account of one such consultation. In an earlier article, we provided an analysis of the manner in which services to elder abuse victims varied with the type of abuse from which they suffered (Sengstock et al., 1989). In the present paper, our attention is focused on the theoretical model under which services are provided to the elderly victims. We will review the types of services provided, as well as the caseworker's assessment of the

case outcome, in elder abuse cases handled under two different types of service delivery models. The nature of the service models and a description of the data collected will be provided in the two sections that follow.

Methodology

This analysis is based on data collected as part of the Elder Abuse Demonstration Projects conducted by the Illinois Department on Aging, under a directive from the Illinois state legislature. The projects began in March and April, 1985, in four different areas of the state, and lasted until June 30, 1987 (Illinois, 1984; Traxler, 1986:156–58). Service providers in the demonstration projects followed a specific model of service provision; data were collected and compared in order to evaluate the most effective means of serving abused and neglected elders.

There were some similarities in each of the four projects. Each required that the responsible agency initiate contact with the alleged victim of elder abuse within 24 hours. The agency was also required to manage the case; this included developing a care plan, selecting a service vendor, and monitoring progress on a monthly basis. Agencies responsible for case management were highly diverse, and varied considerably by geographic area; they included senior service agencies, visiting nurses, family social service agencies, and domestic violence agencies, to mention a few. State guidelines also guaranteed the autonomy of the client and allowed him/her to terminate services at any time (Hwalek, 1987:5–8).

Description of the Four Model Projects

The model projects were established in four different areas of Illinois. The services provided to elder abuse victims within each project were based on a specific model of service delivery. There were two major program models, with one of the program types further subdivided into two subtypes. The program models were as follows:

Law Oriented Program Models

Mandatory Reporting Model.
This project implemented an approach that is based on the service system used for abused and neglected children. It has been used in most states that have enacted elder abuse laws, and requires that certain professionals who work with aged persons report suspected cases of elder abuse to specified state agencies. It also requires that the agency be responsible for receiving the reports to instruct

the mandated professionals as to the nature of the abuse that must be reported. This approach was followed in the area that will be known as "Rural 1."

Legal Intervention Model.

This model emphasized the use of the legal system for providing services to victims of elder abuse, focusing on such services as restraining orders, complaints to the police and the courts, and the collection of accurate case data for use in possible prosecution. The Legal Intervention Model was used in the area known as "Suburban 1."

Advocacy Model (High Service)

This approach views the service provider as an "advocate," assisting the elderly victim in defining and working toward specific goals. It assumes the lowest level of intervention on the part of the worker, but at the same time, it advocates a broad use of formal and informal services in assisting the aged victim in dealing with the problem. This approach was used in two areas, known as "Suburban 2" and "Rural 2."

Workers in the various agencies providing the services were responsible for the collection of data. SPEC Associates of Birmingham, Michigan, handled data entry and management. Data collected during the calendar year 1986 are included in the present paper. Data were collected through the use of nine separate instruments; these included report and intake forms, instruments for the assessment and verification of abuse, service plan forms, worker activities reports, and evaluation forms (Hwalek, 1987:8–11). Personnel at SPEC Associates provided training on data collection to the workers and took considerable pains to supervise the data collection process.

The value of the data for research purposes are necessarily limited, to some degree, by the nature of the study. First of all, the agencies' major concern focused on the provision of services, rather than the collection of data. Hence, data were collected not solely for research, but to enable agencies to verify their payment claims for client services. As a result, modifications were often necessary to adapt the data for research purposes. Second, the diverse nature of the projects assured that a large number of workers over a broad geographic area would be involved in data collection. Even extreme efforts to maintain comparability would be taxed. Third, data collectors were primarily service workers, many of whom are resistant to a task that they feel is secondary to their main goal or that may even inhibit it. Their basic reluctance may limit the value of the data.

Finally, these data represent cases reported at a specific point in time in specific areas of a single state. While there is little reason to believe that Illinois is unique, it may possess characteristics that could limit the applicability of the findings. Illinois is located in the Midwest and is composed of a mixture of urban and rural areas. Also, the Department on Aging is unique in that it has a statewide program that offers assessment and case management services to all elderly, regardless of income level.

The four projects focused on widely diverse areas of the state. Since variation in the program model is the key variable to be considered here, it should be noted that there is no clear distinction in the present data between the program model and the nature of the community in which the program was located. That is, it is impossible to separate any differences resulting from the program model from those resulting from characteristics of the community in which it was located. This is particularly problematic with regard to the two variations of the legal model, where one is located in a rural area, and the other in a suburban area.

The definitions of elder abuse employed in this analysis are those in use in the state of Illinois. There are seven categories of abuse in the Illinois definition: Physical Abuse, defined as "the infliction of physical pain"; Sexual Abuse, that is defined as "the penetration, touching, or fondling of the sex organs, anus, or breasts of the elder through physical force, or when the elder is incapable of giving consent"; Confinement, or restriction of the freedom of the individual "for other than medical reasons"; Deprivation, or preventing the elder from obtaining services necessary to health; Financial Exploitation, defined as using the financial resources of an elderly person to his or her disadvantage; Neglect, or the failure of a caretaker to provide needed services for an elderly person under his/her care; and Self Neglect which consists of the failure of an aged person to obtain the needed services for him/herself (Hwalek, 1987:1–3). If the worker assigned to investigate a report determined that one or more of the types of abuse or neglect reported was "substantiated" or highly suspected, then that was considered to be a case of abuse for the purposes of this study.

Some modifications of the data were necessary for the purposes of analysis. Sexual Abuse was omitted from consideration since no cases were reported during the data collection period. Because only a small number (6) of Confinement cases were observed, it was decided to consider Confinement and Deprivation cases together. This seemed appropriate because of a conceptual similarity between the two categories, both of which represent an active restriction of the elder's activities or access to services, and because service providers tended to handle both types of cases in similar ways (Sengstock et al., 1987).

Service Types

Service providers had twenty different types of services available to their elderly victims. Thirteen of these were general health or social services: Case Management (including coordination of services and monthly monitoring); Homemaking Aid; Medical Care (or therapy); Home Health Assistance (visiting nurses, for example); Meals Assistance (Meals-on-Wheels, for example); Income Assistance; Supervision and Reassurance (including telephone reassurance); Counseling; Housing or Relocation; Transportation; Socializing (including recreation, home visitors, senior centers); Job Training; and Institutional Placement. Seven legal and crisis services were also available: Police Visits; Crisis Intervention Assistance; Investigation (such as in preparing a court case); Guardianship Orders; Orders of Protection; Court Work; and Miscellaneous Legal Assistance (filing legal papers, legal correspondence, etc.). (For further description of the service types, see Hwalek, 1987:31–36, Table 16.)

Data Analysis

Variation in Services as a Function of the Program Model

If service providers were to follow the dictates of the theoretical model under which he/she worked, we would expect that the levels of different types of services would be quite different in each of the projects. The Law Oriented Models (Suburban 1 and Rural 1) should be exceptionally high in the use of legal interventions. The two Advocacy Models (Suburban 2 and Rural 2) should have high rates of service in general. The Mandatory Reporting Model (Rural 1) should have higher rates of reported cases. Similarly, because of the nature of legal services, in which the "service" (i.e., prosecution) is provided to the abuser rather than the victim, we would expect abuser services to be more frequent in Law Oriented Programs than in Advocacy Oriented ones.

Indicated in Table 1 are the mean number of service types provided in the four model programs. As can be seen in the table, one of the two Law Oriented Programs (Rural 1, which focused on Mandated Reporting) had a higher mean number of services than the other three (2.95). Interestingly, the lowest mean was for one of the two Advocacy Oriented Programs, which theoretically focused a high level of service (Rural 2, with a mean of 1.92).

Since the highest volume of service types occurred in a Law Oriented Program, our first hypothesis, that Advocacy Models will have the highest level of services provided, is not borne out. One is tempted to conclude that the provision of a variety of services might be more difficult in rural areas, where such services might be expected to be less available. However, the fact that

the highest mean occurs in another rural area suggests that this is too simple an explanation. Clearly a variety of services can be provided in rural areas. It is difficult to understand, however, why the lowest mean number of services occurs in a program that should focus on high service levels. It may be that this area had high levels of a few services, rather than a variety of services. It is also possible that a broad variety of services were not available in this community. Or, with its advocacy focus, case workers might have more easily accepted the victims' desires to refuse services.

Table 1.
Number of Services and Service Recipient

| | Total Sample | Law Oriented | | Advocacy High Service | |
		Mandated Reporting Rural 1	Legal Intervention Suburban 1	Rural 2	Suburban 2
Mean Number of Service Types	2.67	2.95	2.54	1.92	2.52
Service Recipient:					
Unknown	2 1.0%	1 1.3%	1 1.4%	0 0.0%	0 0.0%
Victim	170 83.3%	76 95.0%	48 64.9%	24 96.0%	22 88.0%
Abuser	1 0.5%	0 0.0%	0 0.0%	0 0.0%	1 4.0%
Both	31 15.2%	3 3.8%	25 33.8%	1 4.0%	2 8.0%
	N=204	N=80	N=74	N=25	N=25

Total N=204
Total Abuse Cases=136

Our second hypothesis focused on the question of services to the abuser. As indicated in Table 1, services were rarely provided to the abuser alone. However, our prediction that services to the abuser would be more frequent in Law Oriented Programs, is borne out; for we find that the Legal Intervention Program (Suburban 1) is far more likely than any of the other programs to provide services to the abuser as well as to the victim. One-third of their cases involved services to both abuser and victim, as opposed to only two or three cases in each of the other programs. The other Law Oriented Program could be

expected to provide relatively few services to abusers also, since it focused only on mandatory reporting, rather than on legal intervention.

Turning to an analysis of the nature of the services, we can see from Table 2 that the service patterns were quite different under each of the four programs. Although all of the programs provided Case Management services to the vast majority of their cases, one of the Advocacy Programs (Suburban 2) provided them to a considerably smaller percentage (80% vs. 100% in each of the others). This area is also considerably lower than the other programs in providing Homemaking Assistance (8.0% vs. 34.8% for the sample as a whole). In contrast, the levels of other types of services, such as Miscellaneous Legal Services and Counseling, tend to be higher here than in other programs (32.0% and 28.0% vs. 24.5% and 13.2%, respectively). This program is also higher than others in the percent of cases receiving Institutional Placement (28.0% vs. 14.7%).

An analysis of the approach that workers in this program take toward their cases indicates that they tend to define their role somewhat differently from other workers. While agencies in the other programs tend to view their role as case managers, referring abuse victims to other agencies for the actual services, workers in Suburban 2 tend to maintain a closer contact with the cases, providing the actual counseling services themselves. Hence, this program appears lower in the Case Management category and higher in the Counseling category. It is less clear, however, why Homemaking Assistance should be so much lower, and Institutional Placement should be considerably higher (over one-fourth of the cases), in this area than in the others.

The other Advocacy Oriented Program (Rural 2) appears to provide services other than Case Management to rather few of the clients. Only one service, Homemaking Assistance, was provided to one-fifth or more of the clients. Two other services, Miscellaneous Legal and Home Health services, were provided to between 10 and 20 percent of the cases. All other services were provided to fewer than 10 percent of the clients. Since this area theoretically should focus on providing a high level of services, it is difficult to understand why this pattern appears. This system does not, however, measure the level of each service provided. Hence it is possible that the clients received a high level of each of the few services provided.

The highest level of services of all types was provided in Rural 1, a Law Oriented Program. In addition to Case Management, half of their clients received Homemaking Assistance (vs. 34.8% in the sample as a whole). Over 20 percent received two other services (Medical Care/Therapy, 26.3%; and Miscellaneous Legal Assistance, 21.3%). And five services, none of them legal in character, were provided to between 10 and 19 percent of the clients. These were

Table 2.
Types of Services Provided by Program Model

| | Total Sample | | | Law Oriented | | | | | | Advocacy High Service | | | | | |
| | | | | Mandated Reporting Rural 1 | | | Legal Intervention Suburban 1 | | | Rural 2 | | | Suburban 2 | | |
Service Type	No.	Pct.	Rank	No.	Pct.	Rank	No.	Pct.	Rank	No.	Pct.	Rank	No.	Pct.	Rank
Case Management	199	97.5%	1	80	100.0%	1	74	100.0%	1	25	100.0%	1	20	80.0%	1
Homemaking Asst.	71	34.8%	2	40	50.0%	2	24	32.4%	2	5	20.0%	2	2	8.0%	*9
Misc. Legal Asst.	50	24.5%	3	17	21.3%	4	22	29.7%	3	3	12.0%	4	8	32.0%	2
Med. Care/Therapy	33	16.2%	4	21	26.3%	3	9	12.2%	*6	0	0.0%		3	12.0%	*7
Inst. Placement	30	14.7%	5	15	18.8%	5	7	9.5%	8	1	4.0%		7	28.0%	*3
Superv./Reassure	29	14.2%	6	10	12.5%	8	12	16.2%	4	2	8.0%		5	20.0%	5
Counseling	27	13.2%	7	11	13.8%	7	9	12.2%	*6	0	0.0%		7	28.0%	*3
Home Health Asst.	25	12.3%	8	9	11.3%	9	11	14.9%	5	4	16.0%	3	1	4.0%	
Meals Assistance	21	10.3%	9	12	15.0%	6	6	8.1%	9	1	4.0%		2	8.0%	
Income Assistance	13	6.4%	*10	7	8.8%	10	2	2.7%		2	8.0%		2	8.0%	
Housing/Relocation	13	6.4%	*10	3	3.8%	13	4	5.4%	10	2	8.0%		4	16.0%	6
Police Visit	10	4.9%	12	5	6.3%	11	2	2.7%		1	4.0%		2	8.0%	*9
Transportation	7	3.4%	*13	4	5.0%	12	1	1.4%		1	4.0%		1	4.0%	
Guardian Order	7	3.4%	*13	1	1.3%		2	2.7%		1	4.0%		3	12.0%	*7
Socializing	4	2.0%	15	0	0.0%		2	2.7%		0	0.0%		2	8.0%	
Job Assistance	2	1.0%		1	1.3%		1	1.4%		0	0.0%		0	0.0%	
Protection Order	2	1.0%		0	0.0%		0	0.0%		0	0.0%		2	8.0%	
Court Work	2	1.0%		0	0.0%		0	0.0%		0	0.0%		0	0.0%	
Investigation	0	0.0%		0	0.0%		0	0.0%		0	0.0%		0	0.0%	
Crisis Intervention	0	0.0%		0	0.0%		0	0.0%		0	0.0%		0	0.0%	
	N=204			N=80			N=74			N=25			N=25		

*denotes tied ranks

Institutional Placement, Supervision/ Reassurance, Counseling, Home Health Assistance, and Meals Assistance.

Suburban 1 closely approximates Rural 1 in the variety of service types provided to their clients. This similarity is not surprising in view of the fact that both are Law Oriented Programs. Nearly one-third of Suburban 1 clients (32.4%) received Homemaking Assistance. As expected, Suburban 1 also had a somewhat higher rate of providing Miscellaneous Legal Assistance (29.7% vs. 24.5% for the sample as a whole). This rate was not as high, however, as the rate for Suburban 2 (an Advocacy area), which provided this service to 32.0% of their cases. As with the other Law Oriented Program, a number of nonlegal services (Medical Care/Therapy, Supervision/Reassurance, Counseling, and Home Health Assistance) were provided to 10 to 19 percent of the cases in Suburban 1.

Thus, our major hypotheses concerning the types of services provided in each area do not seem to be borne out. The Legal Intervention Program had a fairly high, though not the highest rate, of providing legal assistance. The two Advocacy Oriented Programs, which focused on high service levels, did not have the highest rates of providing a variety of services. One Advocacy Program provided a wide variety of services, while the other provided little more than Case Management.

The two Law Oriented Programs, emphasizing Mandatory Reporting (Rural 1) and Legal Intervention (Suburban 1), might have been expected to take a somewhat legalistic, nonservice oriented approach to their cases. Yet these were the areas that provided the greatest variety of services to their clients. Conversely, one Advocacy Program provided a higher rate of legal services than either Law Oriented Program. We are forced to conclude that the nature of the services that elderly abuse victims receive must be based on some factor other than the nature of the theoretical model under which the services are provided.

Variations in Case Outcomes

One might argue, of course, that the type of services that clients receive is not the most important criterion of the success of a program. The real test of a program's success is the outcome for the client. If, in the service worker's best judgment, the client's position is improved, then the case has had a successful outcome, regardless of the nature of the program. We turn now to an analysis of the disposition of the cases as seen by the worker in charge. Did the worker believe that the client was now in a safe environment? Were the client's goals achieved? Or, on the other hand, had the client or his/her family terminated services prior to the achievement of a stable situation? In this analysis, we

consider only those cases closed during the period of the study. There were 87 cases closed during 1986. In each case, the worker's assessment of the final disposition was listed. In a few cases, two dispositions were listed. We have, however, only analyzed the first one listed. The data on final disposition are listed in Table 3.

As the table indicates, the most frequently listed disposition in the sample, as a whole, is the assessment that the case was "safe and stable," listed for 28.7 percent of the cases. This was about twice the number of cases as for the next most frequent category, which was actually a conglomerate of dispositions that could not fit into any of the other categories; these accounted for 14.9 percent of the cases.

Other categories, with 10 percent or more of the cases, also present an interesting picture. In 13.8 percent of the cases, the client had entered a long term care facility and was presumably receiving assistance from another agency. The client's refusal of further assistance represented the final outcome in a substantial number of cases: in 13.8 percent of the cases, the client had refused additional assistance; in another 10.3 percent, the client had even refused to allow an initial assessment. This amounts to a total of 24.1 percent of cases in which the termination of the case resulted from a decision on the part of the client not to accept services.

The pattern of case dispositions from one program to another is particularly interesting. One Law Oriented Program (Suburban 1) and one Advocacy Oriented Program (Rural 2) both follow the pattern of the sample as a whole, in that the most frequent estimate of the outcome was that the case was "safe and stable" (38.1% in Suburban 1; 33.3% in Rural 2). In the other Advocacy Oriented Program, (Suburban 2), however, the most frequent outcome listed is the miscellaneous category (46.7%). In the other Law Oriented Program (Rural 1), the most frequent outcome was the client's refusal of further service. Since Rural 1 was testing a Mandatory Reporting Model, the question might be raised as to whether mandatory reporting might have a deleterious effect on client rapport, resulting in a termination of services. Alternatively, perhaps a Mandatory Reporting Model may produce a larger number of cases in which the elderly is less frail and consequently, less in need of assistance.

It should be noted that the two rural areas both seem to have problems with client refusals. As noted, the most frequent outcome in Rural 1 was the client's refusal of more assistance (27.6%); another 20.7 percent refused an initial assessment. Hence nearly half (48.3%) of their clients terminated services at some point. In Rural 2, client termination of services was considerably lower, though still fairly high. Of clients in this area, 11.1 percent refused initial assessment, and 16.7 percent refused services at a later point, for a total of 27.8 percent

Table 3.
Disposition of Cases by Program Model

| | Total Sample | | | Law Oriented | | | | | | Advocacy High Service | | | | | |
| | | | | Mandated Reporting Rural 1 | | | Legal Intervention Suburban 1 | | | Rural 2 | | | Suburban 2 | | |
Disposition	No.	Pct.	Rank	No.	Pct.	Rank	No.	Pct.	Rank	No.	Pct.	Rank	No.	Pct.	Rank
Case Safe & Stable	25	28.7%	1	6	20.7%	*2	8	38.1%	1	6	33.3%	1	5	33.3%	2
Miscellaneous	13	14.9%	2	3	10.3%	5	3	14.3%	*3	0	0.0%		7	46.7%	1
Refuses More Assistance	12	13.8%	*3	8	27.6%	1	1	4.8%		3	16.7%	*3	0	0.0%	
Enter Long Term Care	12	13.8%	*3	4	13.8%	4	3	14.3%	*3	4	22.2%	2	1	6.7%	
Client Refused Assessment	9	10.3%	5	6	20.7%	*2	0	0.0%		2	11.1%		1	6.7%	
Death of Client	8	9.2%	6	2	6.9%		3	14.3%	*3	1	5.6%		2	13.3%	
Goals Achieved	4	4.6%	7	0	0.0%		4	19.0%	2	0	0.0%		0	0.0%	
Client Needs Changed	3	3.4%	8	0	0.0%		0	0.0%		3	16.7%	*3	0	0.0%	
Moved Out of Area	1	1.1%		1	3.4%		0	0.0%		0	0.0%		0	0.0%	
Enter Hospital	0	0.0%		0	0.0%		0	0.0%		0	0.0%		0	0.0%	
Change Service Volume	0	0.0%		0	0.0%		0	0.0%		0	0.0%		0	0.0%	
Abuser Refuses Access	0	0.0%		0	0.0%		0	0.0%		0	0.0%		0	0.0%	
	N=87			N=29			N=21			N=18			N=15		

*denotes tied ranks

who terminated services. These high refusal rates may be due to the Advocacy Model, in which the case worker's overriding concern is to allow the client to decide if and when he/she will receive services. Workers in this area still considered the largest percentage of the cases to be "safe and stable" (33.3%), however.

A final issue might be raised with regard to the question of case outcome. It is difficult to understand the case workers' judgments regarding the case outcomes when the terms used for categorizing the disposition are as ambiguous as those presented here. In large part, the categories were determined by the workers themselves, rather than the evaluating agency. Consequently, they are categories that the workers deemed useful. More clearly defined outcomes are needed in future studies of this nature.

The most frequently used category, for example, is one in which the worker indicates that the case is "safe and stable." This category is of dubious value, either for research or clinical purposes. Research on elder abuse and neglect suggests that these cases are highly volatile. The factors that are related to abuse are complex and prolonged (Galbraith, 1986). Even though abuse has been terminated, there is always a strong possibility that it may recur should there be a change in any of several factors in the family situation. Also problematic is the fact that the second most frequently used disposition is the "miscellaneous" category.

In both instances, the disposition is not descriptive of the outcome of the case or of any problems that may remain. From a research perspective, these categories provide little understanding of the effectiveness of the interventions employed. From a clinical point of view, these dispositions provide no guidance to other workers who may later handle the case should it be reactivated. Theoretically, such information should appear in case notes, but these too are often missing.

The categories are also of limited value for appraising the effectiveness of the programs. The major finding in terms of disposition is the frequency of service termination in rural areas. Is the Mandated Reporting Program weaker because its most frequent outcome is a refusal of further services? Or does this reflect only a greater degree of frankness on the part of the workers in this program? It is also possible that a larger number of healthy elderly may be referred to the program because of the professional obligation to report, resulting in a large number of clients who neither want nor need services. The most frequently used dispositions provide little information because of their ambiguity. Can we conclude that Suburban 2 is less effective than the other Advocacy Program because its most frequent outcome is "miscellaneous" rather than "safe and stable"? Or does this simply reflect a

difference in terminology? The current categories do not provide answers to these questions.

This suggests the need for a different set of disposition categories that are more descriptive of the resolution of the case. We might suggest, for example, that categories might indicate the reasons why the case was judged "safe and stable." Sample categories might include "victim removed from abuser's home," "caregiver receiving respite," "abuser in counseling," and so on. Alternatively, categories could describe the degree of success of the outcomes, such as "victim recovered from injuries," "some recovery of financial loss," etc. Since the data do not provide greater detail on case outcomes, these can be only suggestions. Analysis of case notes could suggest more appropriate categories.

Discussion

Analysis of the data in this study can suggest strategies for clinical sociology, not only in terms of service delivery techniques, but also in research procedures for applied settings. Results supported only one hypothesis about the impact of service delivery models on elder abuse services: more services were provided to both victim and abuser in one of the legal intervention models.

Program Factors

Since all of the other hypotheses were not supported, we are led to conclude that some factors other than the program model were responsible for the level and type of services provided under each program, as well as the outcome of the cases. We will suggest some of these factors, focusing on the clients, workers, agency, and community.

Client-centered Factors.

Client needs are an obvious reason why workers in any program might deliver services other than those that the program emphasized. Workers in all of the Illinois elder abuse programs were strongly committed to the proposition that the needs of the client were of utmost importance. They frequently referred to the necessity of employing intervention strategies that did not conform to program guidelines if they felt the client's needs warranted such action (Hwalek, 1987:41).

Such action on the part of service workers should indicate the need for caution in the implementation of new programs of all types, for such programs are generally based on an analysis of the prevailing needs of the majority of clients in a specific category. While the proposed services may be highly valuable to

this dominant type, they may not be applicable to all. Individual differences may make the program inadequate for some clients. For others, the program may be entirely inappropriate. It is up to the individual worker, in analyzing the needs of his/her client, to apply the general program to the specific case. The Illinois elder abuse workers clearly felt the need to make adjustments in the program for some cases. This need may be reflected in the lack of conformity between program and service type.

Worker-centered Factors.

Variations in the characteristics of service workers in each program may also have played a role in altering the program service patterns. Workers implementing the programs were not newly hired for these projects; most had previously served in the agencies in some other capacity. Social service workers may vary on a number of dimensions, including field of original professional training, level of expertise, commitment to their professional roles, and level of commitment to the program.

As Tobin and Gustafson (1987) have pointed out, gerontological workers come from a wide variety of professional backgrounds, each with its own set of theoretical assumptions about the nature of human behavior and the needs of persons in trouble. A similar observation has also been made about social workers (Cocozzelli, 1987). While the Illinois Department on Aging went to considerable effort to train the project workers and introduce the philosophical basis of the model under which they would operate, the assumptions of such training may conflict with the propositions developed in some of the workers' professional training. In such instances, we would expect the workers to experience conflict between the recommendations of the program and their long held professional convictions about client needs.

Consequently, professional variations among workers and their degree of commitment to the new program are additional variables that may account for the lack of congruity between program and service type. In fact, the workers' concern for client needs, mentioned in the preceding section, may stem from these individual professional convictions. Consequently, it is difficult to determine whether deviations from the program model are due to a variation in actual client needs or to variations in the workers' perceptions of these needs.

Agency-centered Factors.

The social agencies, like the workers, do not come to the programs as *tabulae rasae*. They too have developed their own sets of procedures, priorities, and techniques for assisting clients. As numerous sociologists have pointed out, such bureaucratic procedures are not easily overcome (see, for example, Hage

and Aiken, 1970). Hence, an agency that is accustomed to referring a frail elder to home health services or placing him/her in a nursing home does not need to look far for a reason why such a referral is more appropriate to the client's best interest than referral to a legal agency. Consequently, some social agencies, without deliberate intent to do so, may have disregarded the program model under which they operated.

Community-centered Factors.

Finally, each program was affected by the services actually available in the community in which it was located. While we must presume that each program was provided with sufficient resources of the appropriate type, there is no control for the services of this type that may have been available in all of the programs. For example, the Law Oriented Programs may have had sufficient legal services available to carry out their mandate. But an Advocacy Oriented Program (such as Suburban 2) might also happen to have legal services available. In fact, this community happened to have an attorney who was interested in the problem of elder abuse and had made legal services available to service workers. Under the mandate of an advocacy program, workers should also be referring their clients to these services. Such service patterns could also account for the lack of correspondence between service type and program.

Methodological Considerations

Finally, this study might suggest some conclusions in terms of research approaches for use in agency settings. As we noted earlier, there are a number of problems that arise in conducting such research. Due to the primacy of service provision in agency activities, research requirements necessarily assume a secondary role. This has consequences for the nature of the data collected, as well as the training and commitment of the data collectors. Hopefully, our experience can suggest methods for accommodating the requirements of both research and service provision.

Collecting Data for Dual Purposes.

All agencies are required to collect data for a variety of reasons. They must provide documentation of numbers, types of clients served, and services provided in order to justify continued existence of the agency and the appropriate level of compensation for agency activity. Even though they may find it annoying, agency personnel, at least at administrative levels, usually recognize the need for such data. The collection of research data is resisted because these are seen

as additional tasks requiring time and attention but not accruing to the benefit of the agency or its clients.

Consequently, research efforts in agency settings will be improved if researchers can develop data collection techniques accommodating the needs of both research investigation and service documentation. For example, researchers may agree to assist agency personnel in developing methods for more effective reporting of agency activities, or they may agree to work with agency staff in the development of grant proposals to obtain further support. Such assistance on the part of research staff would go far in obtaining the cooperation of agency administrative personnel who understand only too well the need for establishing stable financial support.

Co-opting Service Personnel for Research.

Obtaining the cooperation of administrative staff, however, does not necessarily assure the cooperation of field personnel, whose assistance is necessary if accurate data are to be collected. If agency goals and procedures must be accommodated in the development of service-based research projects, the same can be said for the objectives and aspirations of the personnel asked to perform the tasks of data collection for the project. Unlike independently controlled research, agency-based research cannot rely on personnel who have a unique training and commitment to research. Instead such projects depend on data collection by personnel whose training and commitment is to the provision of services and the needs of clients. Frequently, their research efforts are less than wholehearted, due to a conviction that these activities are, at best, depriving them of time and effort that should be spent on behalf of their clients. At worst, they may even see these activities as detrimental to their own or their clients' interests.

To obtain effective data collection under such circumstances, researchers must convince agency workers that the data collected are not detrimental to their clients and may even assist in their service work. If researchers, for example, could develop a set of categories for case outcomes that workers could see to be relevant to their needs, this might lead to greater commitment to the research and willingness to be trained and involved in data collection. Such categories might include items that would make it easier for workers to categorize their cases, and more meaningful when they or their successors must revive a case several months later. Had our project been in a position to develop such categories, our data might have been more useful, not only for research purposes but also for the workers themselves. Hopefully future studies may make more effective use of such techniques.

In a similar vein, human service workers often find themselves pressed to develop periodic reports of client progress or staff activities that also take

time away from their major client-centered tasks. If researchers can develop techniques that assist workers in such time-consuming and undesirable tasks, they might find them more responsive to data collection efforts.

Conclusion

This analysis has found little relationship between the theoretical model of service delivery in effect in a program and the nature of the services that are provided to elderly victims of abuse and neglect. While law-oriented programs might be expected to have higher levels of legal services, it was found that advocacy programs may be equally likely to provide legal services to their clients. Conversely, a law-oriented program was found to provide higher levels of nonlegal services than a program focusing on high service delivery.

We have suggested that several factors other than the theoretical model probably account for case workers' decisions as to the services that should be provided to clients. These include factors focusing on the client and his/her needs, the professional background and philosophical orientation of the worker, characteristics and resources of the agency, and the resources available in the community.

Unfortunately, the data available did not allow verification of these hypotheses, a difficulty that often arises with research based in social agencies. Such problems should not allow researchers to be deterred from conducting such research, however. Many important questions about social behavior and the solution of social problems can be obtained from data currently existing in agency files. It would be a serious mistake to ignore such data sources due to misgivings regarding their inherent problems. Our experience has also suggested several techniques that may improve such agency based research efforts. Hopefully these methodological suggestions may lead to the development of further research that may confirm or refute the validity of the hypotheses proposed.

REFERENCES

Block M., and J. D. Sinnott
     1979   *The Battered Elder Syndrome: An Exploratory Study.* College Park, Md.: Center on
              Aging.
Chen, P. N., S. L. Bell, D. L. Dolinsky, J. Doyle, and M. Dunn
     1981   Elderly abuse in domestic settings. *Journal of Gerontological Social Work* 4:3–18.
Conley, D. M.
     1986   Developing a comprehensive approach: The key for the future. Pp. 177–88 in
              M. W. Galbraith (ed.), *Convergence in Aging.* Vol. 3, *Elder Abuse: Perspectives on
              an Emerging Crisis.* Kansas City, Kans.: Mid-America Congress on Aging.

Cocozzelli, C. L.
    1987   *Social Workers' Theoretical Orientations.* Lanham, Md.: University Press of
            America.
Emlet, C. A.
    1984   Coordinating county based services for the frail elderly: A tri-departmental
            approach. *Journal of Gerontological Social Work* 8:5–13.
Faulkner, L.
    1982   Mandating the reporting of suspected cases of elder abuse. *Family Law Quarterly*
            16:69–91.
Galbraith, M. D.
    1986   Elder abuse: An overview. Pp. 5–27 in M. W. Galbraith (ed.), *Convergence in
            Aging.* Vol. 3, *Elder Abuse: Perspectives on an Emerging Crisis.* Kansas City,
            Kans.: Mid-America Congress on Aging.
Hage, J., and M. Aiken
    1970   *Social Change in Complex Organizations.* New York: Random House.
Hendricks, J., and C. D. Hendricks
    1986   *Aging in Mass Society.* Boston: Little, Brown.
Hickey, T., and R. Douglass
    1981   Neglect and abuse of older family members: Professionals' perspectives and case
            experiences. *The Gerontologist* 21:171–76.
Hwalek, M. A.
    1987   *Elder Abuse: The Illinois Department on Aging's Final Report on the Elder Abuse
            Demonstration Program Act.* Springfield: Illinois Department on Aging.
Hwalek, M. A., and M. C. Sengstock
    1986   Assessing the probability of elder abuse: Toward the development of a clinical
            screening instrument. *The Journal of Applied Gerontology* 5:153–73.
Illinois, State of
    1984   *Elder Abuse Demonstration Project Act.* Illinois Public Act 83–1259.
Kallen, D. J.
    1984   Clinical sociology and adolescent medicine: The design of a program. *Clinical
            Sociology Review* 2:78–93.
Kinderknecht, C. H.
    1986   In home social work with abused or neglected elderly: An experiential guide to
            assessment and treatment. *Journal of Gerontological Social Work* 9:29–42.
Kinney, M. B., R. Wendt, and J. Hurst
    1986   Elder abuse: Techniques for effective resolution. Pp. 110–24 in M. W. Galbraith
            (ed.), *Convergence in Aging.* Vol. 3, *Elder Abuse: Perspectives on an Emerging
            Crisis.* Kansas City, Kans.: Mid-America Congress on Aging.
Lau, E. A.
    1986   Inpatient geropsychiatry in the network of elder abuse services. Pp. 65–80 in M. W.
            Galbraith (ed.), *Convergence in Aging.* Vol. 3, *Elder Abuse: Perspectives on an
            Emerging Crisis.* Kansas City, Kans.: Mid-America Congress on Aging.
Pagelow, M.
    1984   *Family violence.* New York: Praeger.
Pillemer, K., and D. Finkelhor
    1988   The prevalence of elder abuse: A random sample survey. *The Gerontologist* 28:51–
            57.
Salend, E., R. A. Kane, M. Satz, and J. Pynoos
    1984   Elder abuse reporting: Limitations of statutes. *The Gerontologist* 24:61–69.

Sengstock, M.C., and S. Barrett
    1981   Techniques of identifying abused elders. Paper presented at the International Congress of Gerontology, Hamburg, Germany.
    1984   Domestic abuse of the elderly. Pp. 145–88 in J. Campbell and J. Humphreys (eds.), *Nursing Care of Victims of Family Violence*. Reston, Va.: Reston.
    1986   Elderly victims of family abuse, neglect, and maltreatment: Can legal assistance help? *Journal of Gerontological Social Work* 9:43–61.
Sengstock, M. C. and M. A. Hwalek
    1986a   *The Sengstock-Hwalek Comprehensive Index of Elder Abuse*. 2d ed. Detroit: SPEC Associates.
    1986b   Domestic abuse of the elderly: Which cases involve the police? *Journal of Interpersonal Violence* 1:335–49.
Sengstock, M. C., M. A. Hwalek, and S. Petrone
    1989   Services for Aged Abuse Victims: Service Types and Related Factors. *Journal of Elder Abuse and Neglect* 1(4):37–56.
Sengstock, M. C., and J. Liang
    1983   Domestic abuse of the aged: Assessing some dimensions of the problem. Pp. 58–60 in M. B. Kleiman (ed.), *Interdisciplinary Topics in Gerontology*. Vol. 17, *Social Gerontology*. Basel: Karger.
Tobin, S. S., and J. D. Gustafson
    1987   What do we do differently with elderly clients? *Journal of Gerontological Social Work* 10:107–21.
Traxler, A.
    1986   Elder abuse laws: A survey of state statutes. Pp. 139–67 in M. W. Galbraith (ed.), *Convergence in Aging*. Vol. 3, *Elder Abuse: Perspectives on an Emerging Crisis*. Kansas City, Kans.: Mid-America Congress on Aging.
Wolf, R. S., K. T. Halas, L. B. Green, M. L. McNiff
    1985–1986 A model for the integration of community-based health and social services. *Home Health Care Services Quarterly* 6:41–57.

Explaining Delinquent Behavior Among Adolescent Girls: Internal Social Control and Differential Association

Linda P. Rouse
Raymond A. Eve
University of Texas at Arlington

ABSTRACT

Questionnaires were completed by ninety girls participating in a therapeutic wilderness program. Indexes were constructed of problems in school, sexual activities, drug and alcohol use, violent acts, major property offenses, minor property offenses, and miscellaneous misdemeanors. Measures of internal social control were of *attachment* to parents and to school, *commitment* to educational goals, *involvement* in homework, *beliefs* about drug use, and respect for the law. Differential association was measured by questions about *friends' behaviors*. The combined influence of internal social control as a barrier to deviance and differential association as a push toward deviance was examined. Theories used earlier to explain delinquency among boys generally worked well in identifying the correlates of deviant behavior among these adolescent girls, though results varied for the different types of deviance considered. Implications of results for program development are discussed.

Programs intended to address behavior problems among adolescents rest on assumptions about the causes of their behavior. Identifying and empirically testing assumed causes of targeted behavioral problems is an important step in developing and evaluating treatment programs. A variety of existing sociological perspectives claim to explain juvenile delinquency, for example, but relatively little has been published regarding how well these theories might actually work in guiding therapeutic interventions, especially in programs designed to assist female clients. A number of social-psychological theories which have predicted quite well delinquency among teenage boys, particularly the theories of internal social control and differential association, have not been widely used for studies of teenage girls. Meanwhile, the literature pursuing sex role orientation of girls as

a possible predictor of their delinquency involvement has not shown convincing results (e.g., Giordano and Cernkovich, 1979; Shover et al., 1979; Thornton and James, 1979).

Leaving aside debates about the impact of societal level changes in sex roles on girls' *rates* of delinquency (Adler, 1975; Simon, 1975; Klein, 1979; Steffensmeier and Steffensmeier, 1980; Austin, 1982; Siegal and Senna, 1988), we note that (1) girls are far more likely than boys to be incarcerated for status offenses rather than felonies and (2) family functioning has been regarded as particularly important in contributing to the genesis of female delinquency (Robey et al., 1964; Wattenberg and Sanders, 1954; Gibbons and Griswald, 1957; and Baxter and Adams, 1962). The number of teenage runaways in the U.S. has increased to over two million per year and one-fourth of all U.S. women are now pregnant by the age of nineteen, 80 percent outside of marriage (Robertson, 1987). Problems such as these, along with girls' increased involvement in criminal violations and drug use, often lead to referral into clinical intervention programs. Thus, a study of deviance among adolescent girls participating in a treatment and prevention program appears timely and informative.

By the term deviance we do not mean to imply individual pathology, but rather to describe behaviors that violate conventional expectations for appropriate conduct. For a variety of behaviors considered problematic by conventional authority figures in their lives, the girls we studied were referred to a therapeutic wilderness camping program for "troubled" teenage girls that also included a family counseling component. Detailed discussions of therapeutic wilderness camping programs are provided in Roberts (1987a,b), Behar and Stephens (1978), and Callahan (1985). Most important, "there have only been a handful of published follow-up studies describing the effectiveness of wilderness programs, and most of the existing data comes from studies conducted a decade or more ago" (Roberts, 1989b:213). Moreover, to our knowledge, none of the previous studies reported empirical data on girls.

In our study we decided to investigate whether several theoretical perspectives which have been used to explain male delinquency can also help to explain various types of deviant behavior/adjustment problems among adolescent girls. The two theories we focused on were Internal Social Control and Differential Association Theory. Very recently there has developed an intense debate among delinquency theorists concerning whether or not these traditionally distinct theories can—or even should—be combined into an "integrated" theory of delinquency (Messner, Krohn, and Liska, 1989). Some theorists such as Eve (1978) and Elliot (1985) have argued in favor of such an approach, while Hirschi (1989) has argued strongly against such a procedure. Still others, for example,

Swigert (1989) and Gibbs (1989), have argued that it is methodologically premature to attempt integrated theories. We believe that the argument is at least partially misguided, and that the answer depends on what the scholar or practitioner wishes to accomplish.

The pushes toward deviance suggested by differential association theory and the barriers to deviance hypothesized by control theorists may both be operating, in practice, influencing conformity/deviance among adolescent girls. For example, high levels of internal social control can block or inhibit deviant behavior despite external pushes toward deviance (Eve, 1978). Conversely, external pressures may at times be strong enough to overcome internal barriers against participation in deviant behavior. Thus, one idea examined here is whether internal social control can effectively "block" the effects of differential association.

Objectives

In this article we will first review the two social-psychological theories of internal social control and differential association. We will then describe our data collection procedures and characteristics of our sample. The measures used will be discussed at some length in order to provide readers with a clear idea of how the theories were translated into clinically relevant research instruments. We will outline the preliminary findings which led to construction and testing of an impact (intervention) model. Finally, we will review the implications for clinical practice and program development.

Our purpose is to demonstrate that sociological theories can be "successfully" applied to clinical samples. We expect operational indicators of concepts drawn from internal social control and differential association theory to be significantly related to deviant behaviors reported by the Girls' Adventure Trails (GAT) girls.

Hypothesis I   Girls with lower internal social control levels will have higher
                  rates of deviant behavior/adjustment problems.
Hypothesis II   Girls with higher levels of association with delinquent peers
                  will have higher rates of deviant behavior/adjustment problems.

We will test whether the theories explain variation in the deviant behaviors reported by adolescent girls in this treatment program and, if so, we will consider how the theories might be used to build an intervention model. Correspondingly, sociological theories may be shown to provide a foundation—empirically supported by actual client data—for developing more explicit and

valid impact/intervention models by which counselors or agency managers can design programs and evaluate program effectiveness.

For both theories, when obtaining information from girls in the program, questions were included that had been used in previous studies commonly cited in the research literature. While previous empirical evaluations tended to focus on only one dimension of internal control (e.g., beliefs) to the exclusion of others (e.g., commitment) or to examine some sources of conventional attachment (e.g., parents) and not others (e.g., school), the detailed self report instrument we used covered many dimensions. Likewise, a range of deviant behaviors were investigated, including drug use, minor as well as more serious criminal offenses, school problems and sexual behavior. The virtue of this approach is to capture the multidimensionality of both deviant behaviors and the theories which attempt to explain them.

Theoretical Perspectives

As conceptualized and popularized by Travis Hirschi (1969), *social control theory* assumes that people are innately amoral, active, grasping, manipulating, and self-interested. Why, then, do people conform to social norms? One answer is found in sources of external social control (such as police, prisons, public surveillance systems, etc.). Additionally, socialization causes people to internalize the norms and values of their group. They will correspondingly feel anxiety if they act in ways which contradict their socialization. While control may initially have been external during early childhood, i.e., rewards or punishments received from one's caretakers, eventually the attitudes and values of these others become internalized. Society is seen by social control theory as advocating a single set of prosocial values which are assumed to be universally experienced. Thus, deviance is said to be the result of an absence or a failure of the socialization process within a given society. Individuals who are insufficiently connected to conventional beliefs, goals, activities, and relationships with others are expected to be more likely to engage in norm violating behaviors.

Hirschi (1969) described four aspects of socialization which he believes act as social-psychological barriers to deviance: "attachment"; "commitment"; belief"; and "involvement." Social control theory suggests that the more one is emotionally *attached* to conventional socializing agents, such as parents or teachers, the more one will want to please these agents by adopting the prosocial patterns of behavior they advocate. The *commitment* dimension is based on the assumption that the more a person is rationally committed to conventional goals or conventional lines of action, the less likely he/she is to act in deviant ways.

With respect to the *belief* dimension, Hirschi and other control theorists have assumed that once one has internalized conventional beliefs, violation of these beliefs will result in anxiety or other distress. Thus, to the extent that youths give prosocial answers when asked to agree or disagree with items such as, "It's all right to break the law if you can get away with it," we may predict they are less likely to deviate. Finally, the *involvement* dimension reflects the suggestion by control theorists that to the extent a youth is involved in conventional activities (studying, church work, etc.) he/she will be less likely to get into trouble. Such involvement is also expected to increase levels of attachment, commitment, and internalization of conventional beliefs.

One limitation of control theory is that it assumes a single set of prosocial, societywide values. *Differential association theory*, which also emphasizes the impact of socialization on individual behavior, recognizes that society is not, in fact, so uniform in values. Differential association theory assumes, instead, that society is characterized by more than one agreed-upon set of norms. Deviance, like conformity, is viewed as learned through interaction with others, but with others whose attitudes and behaviors are favorable to norm violation. Some criminologists, such as Sutherland and Cressey (1974), have argued that the lower class in general is organized around a set of values conducive to law breaking. Criminal behavior patterns are seen as the product of normal learning from one's associates in the lower segments of society. Sutherland and Cressey refer to this type of learning as being the result of "differential-association," resulting in individuals who have an "excess of definitions and attitudes favorable to law-breaking." In short, deviance is regarded from this perspective as the result of normal and effective socialization, but it is socialization within a group or class which has adopted norms and values that are unusually often criminal. Thus adolescents may associate with peers who promote drug use, sexual activity, cheating, or other behaviors viewed as deviant by the dominant culture.

Sample

The girls who participated in this study were clients in a Girls' Adventure Trails (or, hereafter, GAT) program. Girls' Adventure Trails, located in Dallas, Texas, serves girls nine to fifteen years of age who are referred for a variety of adjustment problems, such as low self-esteem, poor grades, sexual promiscuity, running away from home, defiance of parental authority, drug use and other law breaking. The core service consists of a 26-day wilderness camping trip conducted by young adults with training in counseling as well as wilderness camping skills. The girls' parents are involved in weekly group meetings with

professional staff for four weeks during their daughters' trip and three follow-
ing the trip to work on parenting skills. The entire family is also included in
pre-trip slide shows, interviews, and evaluation conferences, and participates to-
gether in an overnight weekend camping experience. Following the core service,
professional counseling is made available as needed, by request, for six months.

All girls who passed through the GAT program between November 1984
and November 1986 were asked to complete anonymous questionnaires. No
girl refused to complete a questionnaire, although a few omitted some an-
swers. The total number of girls in the present data set represent ten differ-
ent camping trips. The girls were taken to the wilderness by bus. While on
the bus they were asked to complete half of a 21-page questionnaire during
the first day on the road and then were asked to complete the second half
on the next day. Girls were assigned code numbers and were never asked
to give their names. The questionnaires were administered by the trip coun-
selors who are trained interviewers and counselors. The girls had met the
trip counselors and interacted for several hours before the field trip actually
began, so there was already generally good rapport between the counselors
and the girls.

Between November 1984 and November 1986, ninety girls participated in
the wilderness camping experience, in groups of six to twelve. The median age of
the girls in the sample was thirteen. They came from many different junior high
and upper elementary schools in Dallas, Texas and surrounding areas. Their
religious background was predominantly Protestant. Eleven percent were the
only child in their family, while the rest were equally likely to be oldest, middle,
or youngest child. Their fathers' occupation ranged from laborer to professional-
technical. Just over one-fifth of their mothers were not employed. Those working
for wages outside the home had jobs from domestic to professional-technical,
with the highest proportion in clerical. Seventy-eight percent of the girls in this
sample were white, 13 percent black, and 7 percent Hispanic. The most common
referral sources were school personnel (counselors, teachers, administrators),
police juvenile departments or probation officers, and family or friends. Reasons
for referral were most often truancy and failing grades, poor communication
skills, rebelliousness at home, running away, stealing, shoplifting, and fighting.
A deliberate effort is made by GAT to select girls who are having serious
problems but do not yet appear to be "incorrigible."

Measures of Deviance

The various measures of deviant behavior, which appeared in the final sec-
tion of the questionnaire, were sorted into several categories of offenses: (1)

problems in school, (2) sexual behavior, (3) drug and alcohol use, and (4) criminal offenses. Criminal offenses were further divided into (a) violent acts, (b) major property offenses, (c) minor property offenses, and (d) "misconduct," which included a variety of misdemeanor acts not included in the other categories.[1] Indexes for each category of offense were created by summing responses across items in a given category. Measures were drawn from the Short and Nye (1958) delinquency inventory and a similar but more recent and more extensive inventory used by Hindelang, Hirschi, and Weiss (1980).

Measures of Internal Social Control

Each of the four aspects of internal social control are themselves multidimensional. Attachment may be to various persons, commitment may be to a variety of conventional goals, beliefs may pertain to a range of issues, and involvement may be across different types of conventional activities.

1. Attachment Dimension.

Our questionnaire included items on attachment to parents and to school. The specific questions used concerned whether a girl respected her mother (father), wanted to be like her mother (father), shared thoughts and feelings with mother (father) and so on. The index of school attachment consisted of four items which asked how much the respondent liked or disliked school, how many of her current teachers she liked, and whether she cared what her teachers think of her (two phrasings). Attachment to school was found to be independent of attachment to parents.

2. Commitment Dimension.

Commitment was measured in terms of educational goals. The index of educational commitment consisted of five items: the importance to the respondent of learning as much as possible in school; importance of grades to her own satisfaction; whether getting good grades really means a lot to her; her decision to go to college; and, how far she wanted to go with her education. Commitment to educational goals was positively related to school attachment (r=.51, p=.001) but not significantly related to attachment to either parent.

3. Involvement Dimension.

Involvement in conventional activities was measured by two related items concerning how often a girl finished her homework and the number of hours a day she spent doing homework. Involvement in conventional activities was correlated with educational commitment (r=.56) and with school attachment

(r=.35). Like educational commitment, involvement in conventional educational activities was not related to attachment to mother or father for girls in this sample.

4. Belief Dimension.

Internalized conventional beliefs were measured with reference to the girls' attitudes toward drug use and other criminal behavior. Conventional beliefs about drug use included questions about how strongly a girl approved or disapproved of people her age smoking, drinking, taking amphetamines ("speed"), marijuana, LSD, "hard drugs" such as cocaine, and tranquilizers. Other beliefs which might serve as a barrier to criminal behavior, beliefs pertaining to respect for the law, were addressed by asking respondents their level of approval or disapproval concerning the following types of statements: "I have a lot of respect for the police," "It is all right to get around the law if you can get away with it," "People who break the law are almost always caught and punished," and "To get ahead, you have to do some things that are not right."

Measures of Differential Association

As a measure of differential association, we attempted to establish the extent to which respondents held certain definitions favorable to law breaking. Additionally, respondents were asked to describe their perceptions of some of the attitudes and behaviors of their friends. We were looking for the possible connection between a girl's own beliefs about the desirability or undesirability of selected behaviors, her perception of her friends' beliefs and behaviors, and her actual involvement in these behaviors.

Girls in the GAT program were asked specifically how often (from "never" to "very often") their friends used amphetamines, barbiturates, cocaine, LSD, and heroin. Summing responses across these five items produced a reliable index of friends' use of drugs. Girls were also asked how much their friends drank alcohol and how often they cheated on tests, were suspended from school, and were involved in sexual activity. Additionally, for most of these behaviors the GAT girls were asked about their own beliefs.

Findings on Internal Social Control

In short, the suggested overall effect of *attachment to conventional socializing agents* was that it might be serving as a modest, but consistent (for mother, father, and teachers), barrier to criminal behaviors and school adjustment problems. Attachment to conventional socializing agents did not appear to deter

sexual activity, and only attachment to teachers/school was possibly inhibiting drug use. *Commitment to educational goals* was not significantly related to criminal behaviors other than drug use though it had modest inverse relationships with drug use, sexual activity, and school adjustment problems. *Involvement in conventional activities*, specifically homework, was moderately, inversely, related to criminal behaviors and school adjustment problems, somewhat related to less use of drugs and not significantly related to sexual activity. *Internalized conventional beliefs* were most strikingly related to deviant behavior in this sample of girls. Disapproval of drug use was strongly related to reporting not actually using drugs and to less sexual involvement, as well as being consistently (modestly) related to lesser involvement in criminal behavior and school adjustment problems. Prosocial beliefs reflecting respect for the law and disapproval of criminal behavior were strongly related to reduced involvement in violent crime, property crimes, miscellaneous conduct offenses, and school adjustment problems. Prosocial beliefs were also associated with reduced involvement in drug use and, to a lesser extent, sexual activity.

Findings on Differential Association

Our data were also consistent with a differential association interpretation of the GAT girls' adjustment problems. Cheating in school, drinking, and use of illegal drugs were strongly related both to *friends' involvement in the same behavior* and to *internalized definitions (beliefs) favorable to these behaviors.* The greater the number of close friends who had been suspended from school, the more likely a girl was to have been suspended herself (r=.75). Forty-five percent of the girls had skipped school with friends "many times." To a lesser extent, when friends were perceived as more involved in sexual activity, girls were more likely to "make out" with boyfriends (r=.47) and "go all the way" (r=.30). Although the questionnaire did not ask about friends' criminal behavior, recall that beliefs favorable to law breaking were strongly related to the girls' involvement in various types of criminal activity/conduct offenses.

In applying differential association theory to the case of the GAT girls, it was still unclear whether association with peers who engage in deviant acts is directly related to a girl's behavior or whether this effect is mediated by her beliefs. Partial correlations were used to examine relationships among these three variables. The weakest link was the association between friends' behavior and a girl's own beliefs. For example, if we controlled for a girl's own drinking behavior, having friends involved in drinking was not significantly related to her beliefs about drinking. Her behavior, however, was related to her friends' behavior (controlling for her own beliefs) and to her own beliefs (controlling

for friends' behavior). Even if she did not personally favor drinking, she was more likely to drink if her friends drank, and, if she favored drinking she was more likely to drink regardless of whether her friends drink.

Impact of Differential Association and Internal Social Control on Various Types of Deviant Behavior

The most complex question, finally, is about the manner in which internal social control and differential association jointly influence the GAT girls' degree of involvement in deviant behaviors. Figure 1 outlines the causal model underlying this discussion.
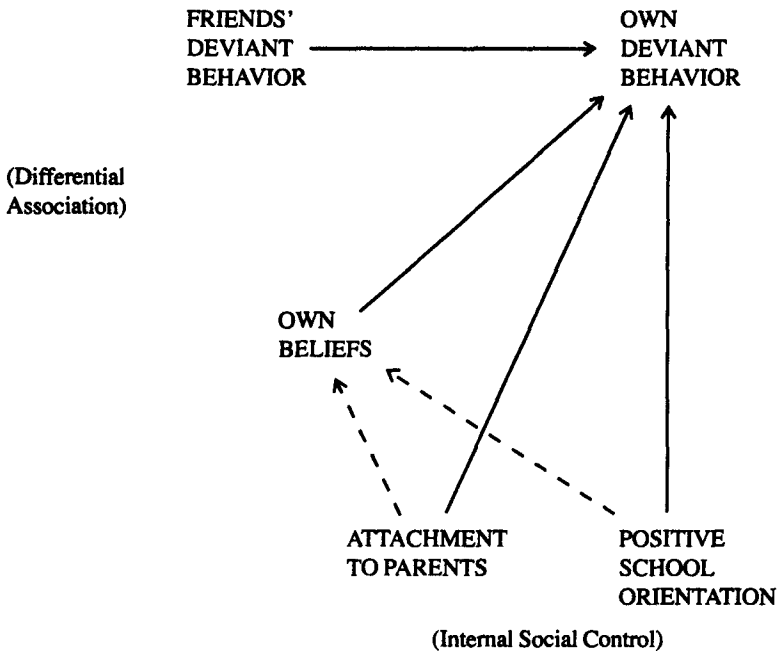
Figure 1. Selected Factors Influencing Delinquency (suggested by Differential Association and Internal Social Control Theories)

Three preliminary points:
1. *School and family appeared to be separate domains within which the GAT girls were more or less "connected" to conventional social institutions.* For girls in this sample, attachment to parents (e.g., respecting them, wanting to be like them, feeling understood and wanted by them) did not necessarily

lead to, nor did it preclude, caring what teachers think of them, aspiring to college, or spending time on homework. To continue the analysis, therefore, we combined measures of school attachment, commitment, and involvement to obtain an index of general positive orientation toward school and combined the measures of attachment to mother and father to create an index of positive orientation toward parents. These appear in Figure 1 as two institutional sources of internal social control.

2. *The concept of beliefs is embedded in both social control (the "belief dimension") and differential association ("excess of definitions favorable to law breaking") explanations of deviance.* As noted earlier, beliefs were the strongest correlate of the GAT girls' involvement in a variety of deviant behaviors/ adjustment problems. Beliefs were therefore treated in Figure 1 as a separate factor relevant to both theoretical perspectives.

3. *Findings varied with the type of deviant behavior being considered.* School adjustment problems and crimes, for example, were significantly related to (lack of) attachment to parents, while drug use and sexual activity were not. Commitment to educational goals was not significantly related to extent of criminal involvement but was modestly related to better school adjustment and less drug use. Most consistent across different types of deviant behavior was the strong inverse relationship with conventional beliefs.

Multiple regression was the statistical procedure we used to analyze the relationships between a given type of deviant behavior and the set of predictor variables suggested in Figure 1. Here, we were considering measures of internal social control and differential association together, to examine the relative effect of each controlling for the other.

Separate items on the questionnaire addressed consumption of alcohol and use of illegal drugs, yet the pattern of results for both sets of items was similar. Multiple R^2 was .72 and .55, respectively. These high values confirm the importance of variables identified in the model for explaining the GAT girls' alcohol and other drug use. Within the model, however, positive school orientation and attachment to parents did *not* contribute significantly, since variance in the girls' behavior was almost entirely explained by friends' use of alcohol/illegal drugs and the girls' own beliefs about drinking and drug use.

The questionnaire did not include a direct measure of beliefs about sex but did include an item on friends' sexual involvement as well as the girls' attachment to parents and school orientation. The most influential factor was friends' sexual involvement. This time the R^2 was down to .23 but the F value was still statistically significant. Most striking, regressing sexual involvement exclusively on school orientation and attachment to parents produced an R^2 of .01: no effect. By contrast, introducing drug use to the original model boosted R^2

to .44 and essentially eliminated the significant contribution of friends' sexual involvement.

For cheating in school, R^2 was .46 and, again, most influential were friends who cheated on tests and a girl's own beliefs about cheating. Apart from her own attitude toward cheating and the influence of friends' cheating, neither positive school orientation nor attachment to parents had a significant effect.

For crimes, recall that we had a measure of prosocial beliefs but no measure of friends' criminal involvement. Also, we noted earlier that the strongest associations with internal social control items had been for criminal behaviors other than drug use. The regression analysis produced an R^2 of .49 and the most balanced contribution of variables from internal social control and differential association theory. (R^2 for regression only on criminal beliefs was .35, identical to the R^2 for regression on school orientation and attachment to parents—in which both variables made a significant contribution to variance explained in criminal involvement.)

Sociological Theory, Research and Clinical Practice

Arguments concerning which of several competing theoretical perspectives is valid appear to be misguided. Differential association and social control theory are frequently treated as mutually exclusive explanations, yet despite fundamentally different starting assumptions they overlap conceptually in the area of beliefs. Since endorsement of prosocial beliefs was inversely related to all types of deviant behavior considered in this paper, each perspective is successful in calling attention to a key variable for understanding variation in the extent of deviant behavior among girls in this sample. Moreover, other measures of both differential association and internal social control were found to be significantly related to various adjustment problems among the adolescents we studied.

We found in this study that theories used earlier to explain delinquency among boys seemed to work quite well in identifying correlates of most types of deviant behavior reported by adolescent girls in the GAT program. The traditional explanations for male delinquency we examined told us least, though, about the motivations behind these teenage girls' participation in sexual activities. This makes sense, considering the sex role bias involved in defining girls' sexual activity as deviant behavior (not so for boys). If preventing premature sexual involvements, unwanted pregnancy, and sexually transmitted diseases is a program goal, a better model is needed. Involvement in drugs, which was clearly associated with greater likelihood of sexual activity, might be included in such a model.

For intervention applications it should also be remembered that different types of problems may respond better to treatments based on one theory rather than another. For example, contrary to popular opinion, attachment to parents did not deter involvement in drugs for these girls. Producing better family relationships is a valuable goal in itself, but may be an ineffective strategy for a program mainly striving to reduce drug use. From the evidence examined in this analysis, efforts would be better spent in dealing directly with girls' attitudes toward drug use, examining the behavior of their peers, and helping them establish new friendships with more conventional girls.

In a detailed empirical analysis of data from a national youth survey, Elliott, Huizinga and, Ageton (1985:145) also concluded, "There is no evidence here that weak conventional bonding leads to delinquency or drug use in the absence of involvement with delinquent peers"; association with delinquent peers "led to some delinquency for all youths whether conventional bonding was weak or strong." Reviewing earlier studies, they noted that attachment to delinquent peers was the strongest correlate of delinquency—whether theft, violence, drug use, or status offenses (p. 75).

With respect to criminal offenses other than drug use, the degree of attachment reported toward parents was clearly an important factor. Greater attachment was related to more prosocial beliefs and to lesser involvement in criminal behavior. Again, Elliott, Huizinga, and Ageton's (1985) findings are germane. They found that the *extent* of involvement in delinquency was dependent on the level of conventional bonding. If associating with delinquent peers, the risk of increased involvement in delinquency was greater for youths with weak conventional attachments. Prosocial attachment attenuates delinquency participation. There is an interaction of influences operating such that rate of delinquency is boosted when there is low conventional bonding in conjunction with involvement with delinquent peers. Conventional bonds were also found to somewhat decrease the likelihood of involvement with delinquent peers.

Neither theory alone was "best" at explaining all types of deviance. Integrated prediction models combining theoretical perspectives can successfully increase "variance explained" (Eve, 1978), and thus are useful in identifying adolescents who are likely to get into some kind of trouble, but this approach obscures differences among clients in treatment programs. No one program using one approach can be successful for all types of girls with different kinds of problems. Effective interventions require a diversity of approaches within a particular program and/or prescreening to select individuals who will best benefit from the particular kind of services offered. Sensitivity to the pushes and the pulls toward deviance/conformity, and how they interact, will be useful.

Additionally, more research to clarify what types of causal variables are most readily subject to manipulation (e.g., *how* to build emotional attachment, commitment to conventional goals, involvement in conventional activities, and associations with others who do not hold definitions favorable to law breaking) would help practitioners apply the insights of theories like differential association and social control in their efforts at individual and social change. Systematic evaluation of actual program effectiveness is also important to ensure that limited resources are used in the most efficient way to accomplish specific goals. Impact models are a useful tool for this purpose.

Rossi and Freeman (1985:60) define an impact model as "the set of guiding hypotheses underlying the planning and implementation of a program." The causal hypotheses of an impact model specify the "influence of one or more processess or determinants on the behavior or condition the program seeks to modify" (Rossi and Freeman, 1985:72). Often programs operate from no more than loose assumptions—untested notions based on practice intuition or on previous studies with questionable generalizability to their own client base. We have demonstrated as an alternative the feasibility of research designed to apply sociological theories to particular client populations. The result for program managers/service providers is a clearer picture of determinants of a variety of problems among their clients—in this case, adolescent girls in a delinquency treatment and prevention program.

NOTES

1. A detailed list of specific items used, with response frequencies, is available from the authors on request. The following sample items will give readers a sense of questionnaire content: *school adjustment* — failed a course, cheated on a test, skipped school; *sexual behavior* — "made out" on a date, had intercourse with boyfriend; *drug use* — smoked marijuana, took amphetamines, used heroin; *violent acts* — beat someone up, carried a weapon, committed robbery; *major property offenses* — took a car without permission, broken into a house, set fire to a building; *minor property offenses* — lifted a wallet, kept money collected for charity, took things from someone else's locker; *miscellaneous misdemeanors* — withheld information about a crime, deliberately broke a street lamp, ran away overnight.

REFERENCES

Adler, Freda
    1975   *Sisters in Crime*. New York: McGraw Hill.
Austin, Roy
    1982   Women's liberation and increase in minor, major, and occupational offenses. *Criminology* 20:407–30.

Baxter, Gordon, and W. Adams
    1962   Comparisons of the delinquencies of boys and girls. *Journal of Criminal Law,
              Criminology, and Police Science* 53:470–75.
Behar, L., and D. Stephens
    1978   Wilderness camping: An evaluation of a residential treatment program for emo-
              tionally disturbed children. *American Journal of Orthopsychiatry* 48 (October):
              644–53.
Callahan, R., Jr.
    1985   Wilderness probation: A decade later. *Juvenile and Family Court Journal* 36
              (Spring): 31–35.
Elliott, D., D. Huizinga, and S. Ageton
    1985   *Explaining Delinquency and Drug Use.* Newbury Park, Calif.: Sage Publications.
Elliott, D., S. Ageton, and R. Cantor
    1985   The assumption that theories can be combined with increased explanatory power.
              Pp. 123–49 in Robert F. Meier (ed.), *Theoretical Methods of Criminology.* Beverly
              Hills: Sage Publications.
Eve, Raymond A.
    1978   A study of the efficacy and interactions of several theories for explaining rebel-
              liousness among high school students. *Journal of Criminal Law and Criminology*
              69(1):115–25.
Gibbons, Donald, and M. Griswald
    1957   Sex differences among juvenile court referrals. *Sociology and Social Research*
              42:106–10.
Gibbs, Jack P.
    1981   *Norms, Deviance and Social Control.* New York: Elsevier.
    1989   Three perennial issues in the sociology of deviance. In S. F. Messner, M. D. Krohn,
              and A. E. Liska (eds.), *Theoretical Integration in the Study of Deviance and Crime:
              Problems and Prospects.* Albany: SUNY Press.
Giordano, Peggy C., and S. A. Cernkovich
    1979   On complicating the relationship between liberation and delinquency. *Social Prob-
              lems* 26:467–81.
Hindelang, M., T. Hirschi, and J. Weiss
    1981   *Measuring Delinquency.* Newbury Park, Calif.: Sage Publications.
Hirschi, T.
    1969   *Causes of Delinquency.* Berkeley: University of California Press.
    1989   Exploring alternatives to integrated theory. In S. F. Messner, M. D. Krohn, and A.E.
              Liska (eds.), *Theoretical Integration in the Study of Deviance and Crime: Problems
              and Prospects.* Albany: SUNY Press.
Klein, Dorie
    1979   The etiology of female crime: A review of the literature. Pp. 69–71 in Freda Adler
              and Rita Simon (eds.), *The Criminology of Deviant Women.* Boston: Houghton
              Mifflin.
Messner, Steven F., Marvin D. Krohn, and Allen E. Liska
    1989   *Theoretical Integration in the Study of Deviance and Crime: Problems and Pros-
              pects.* Albany: SUNY Press.
Roberts, Albert R.
    1989a   *Juvenile Justice: Policies, Programs, and Services.* Chicago: Dorsey Press.
    1989b   Wilderness experiences: Camps and outdoor programs. Chapt. 10 in A. Roberts
              (ed.), *Juvenile Justice: Policies, Programs and Services.* Chicago: Dorsey Press.

Robertson, Ian
  1987   *Sociology*, 3d ed. New York: Worth Publishers.
Robey, Ames, R. Rosenwal, J. Small, and Ruth Lee
  1964   The runaway girl: A reaction to family stress. *American Journal of Orthopsychiatry*
            34:763–67.
Rossi, Peter H., and Howard E. Freeman
  1985   *Evaluation: A Systematic Approach*, 3d ed. Beverly Hills: Sage Publications.
Siegel, Larry J., and Joseph J. Senna
  1988   *Juvenile Delinquency: Theory, Practice, and Law*, 3d ed. St. Paul: West.
Simon, Rita Jane
  1975   *Women and Crime*. Lexington, Mass: Lexington Books.
Short, James F., and F. Ivan Nye
  1985   Scaling delinquent behavior. *American Sociological Review* 22:328.
Shover, Neal, S. Norland, J. James, and W. Thornton
  1979   Gender roles and delinquency. *Social Forces* 58:162–75.
Steffensmeier, Darrell, and Renee Hoffman Steffensmeier
  1980   Trends in female delinquency. *Criminology* 18:62–85.
Sutherland, E., and D. Cressey
  1974   *Criminology*, 9th ed. Philadelphia: J. B. Lippincott.
Swigert, Victoria L.
  1989   The discipline as data: Resolving the theoretical crisis in criminology. In S. F.
            Messner, M. D. Krohn, and A.E. Liska (eds.), *Theoretical Integration in the Study
            of Deviance and Crime: Problems and Prospects*. Albany: SUNY Press.
Thorton, W., and J. James
  1979   Masculinity and delinquency revisited. *British Journal of Criminology* 19:225–41.
Wattenberg, William, and Frank Saunders
  1954   Sex differences among juvenile court offenders. *Sociology and Social Research*
            39:24–31.

Book Reviews

Clinical Sociological Perspectives on Illness and Loss: The Linkage of Theory and Practice, edited by Elizabeth J. Clark, Jan M. Fritz and Patricia Reiker. Philadelphia: The Charles Press, 1990. 340 pp., $21.95 paper.
Russell R. Dynes
University of Delaware

This book is a collection of articles, most not previously published, centering on the contribution clinical sociology can make to the understanding of illness and loss. While the stated intent is to blend clinical sociology and thanatology, the book goes beyond those "limits" to explore the utility of sociological approaches for intervention in illness and loss. The book is a product of a joint effort of the Sociological Practice Association and the Foundation of Thanatology. The Foundation is dedicated to advancing the cause of enlightened health care for terminally ill patients and their family members.

The core of the book starts with Part II—Sociological Explanations of Attitudes Toward Illness and Death. This includes Don Sabo's "Men, Death, Anxiety and Denial: Critical Feminist Interpretation of Adjustment to Mastectomy," Joanne N. Clarke's "The Causes of Cancer: Women Talking," Dorothy Rosenberg's "The Death Certificate as a Reflection of Attitudes," Panos Bardis' "Thanatometer: A Scale for the Measurement of Awareness and Acceptance of Death," and Nancy Kutner's "A Social System Perspective on Cadaver Organ Transplantation," which appends a section on implications for clinical sociology.

Part III constitutes a section on Clinical Ethics, initiated by a "Role Analysis of a Clinical Ethicist" by Hammes and Bendiksen. The role analysis is placed in the context of the institutional review board of a community hospital. This is followed by an article on "Permission to Die: A Case Study in the Social Construction of Reality" by Suzanne Fleming and a case study of the implementation of a Louisiana law which allowed patients to refuse life-sustaining medical procedures. Elizabeth J. Clark deals with the interrelationship between loss and grief in the elderly population, and the section concludes with a Sociological Practice Association's Statement on Ethical Standards of Sociological Practitioners.

Part IV emphasizes Special Populations and Special Problems. Kabele reports on his work as a clinical sociologist in a child oncology clinic in Prague dealing with the mother-child relationship, and Bendiksen contributes an article on "Facing Death With Children." This is followed by Laura E. Nathan's "Coping with Uncertainty: Family Members' Adaptation During Cancer Remission," David Gordon's study of survivors of testicular cancer, and Tamara Ferguson, Jack Ferguson and Elliot Luby's "Role Performance After Loss," which deals with the adaptation of widows in developing a sense of attainment. The section concludes with Masako Ishii-Kuntz's study showing how sociological research can contribute to education on safe sex practices in the prevention of AIDS.

The last section, Part V, deals with organization and structure as sociological variables. In certain ways, these articles might be of most interest to other sociologists. Gear and Haney, in "The Cancer Patient after Diagnosis: Hospitalization and Treatment," deal with transitions to the role and status of cancer patient. They suggest ways hospitals might keep the cancer diagnosis from becoming a master status which overwhelms the patient. Clark, in her "Intervention for Cancer Patients," describes a problem-solving implementation for cancer patients in a mid-sized community hospital which deals with both internal staff changes and the utilization of community resources. Christopher Jay Johnson in "The Sociology of Alzheimer's Wings in Nursing Homes" describes a symbolic interaction assessment of Alzheimer's disease which led to the design and implementation of a low-stimulus environment for chronic patients in a nursing home. That environment seemed to lead to positive changes for the residents as their disease status changed. I found this article to be exceptionally insightful and hope it will become well known in the health care community. The section ends with an article by Kalekin-Fishman and Klingman entitled "Rituals and Ideology: The Case of the Funeral in Non-Religious Kibbutzim." While funerals seem to be an appropriate way to end the book, it would seem that most people die outside the kibbutz and within some religious tradition, so some comparisons with other forms of rituals would have been wise.

While the bulk of the book deals with loss and illness, the first part, Theory into Practice, represents some of the rationale for clinical sociology. Clark's introductory essay on sociology's contribution to the topic included in the book is a valiant attempt to tie in topics and theories. Fritz's article on the uses of sociology in clinical settings is rather detached from the intellectual history of the field. Roger Straus's reprinted article on "Changing the Definition of the Situation: Toward a Theory of Sociological Intervention," Reiker and Begun's "Linking Sociology to Clinical Practice," Cox and Fundis's "Teaching the Sociology of Dying and Death" are all useful in and of themselves but collectively contribute little to an introductory context for the rest of the articles. Instead of

being an "introduction," the first part seems detached from the rest. It would
have been my preference to let the content articles in the book speak for them-
selves since collectively they constitute a better claim for the value of clinical
sociology than does the introduction. It would seem that, as sociologists, we
spend considerable intellectual energy in product differentiation, arguing the su-
periority of our theories, methods, approaches, and topics, usually with some
ghost of the past or some imagined enemy. We would better spend our time
improving our product, not just differentiating it. Certainly, there are a number
of useful products in the book which contribute to our knowledge. Thus, the
book would be useful to those in the sociology of health and could be used
as supplemental readings in several different kinds of courses. Collections of
articles are notoriously hard to put together in a coherent framework, but the
parts still make the book worthwhile.

Marriage and Family Therapy: A Sociocognitive Approach, by Nathan
Hurvitz and Roger A. Straus. Binghamton, NY: The Hayworth Press, Inc. 1991.
300 pp., $29.95 cloth, $17.95 paper.
Beverley Cuthbertson-Johnson

The creative partnership of Nathan Hurvitz and Roger Straus has produced
an important work. The sociocognitive approach developed by Hurvitz in his
clinical practice and refined and concisely articulated by Straus represents an
essential step on the pathway to an integrated framework for applying important
sociological concepts in therapeutic settings.

The first two chapters present the theoretical foundations of the sociocog-
nitive approach. Chapter 1 identifies the macrosociological foundations of so-
ciocognitive theory, stressing the importance of the sociocultural context within
which family members interact and learn their behaviors, meanings, and feel-
ings. Especially significant is a discussion of how established social structures,
such as capitalism and the class system, as well as ethnicity, age/life stage,
sex/gender roles, and social change can play a significant role in personal and
interpersonal problems. Also particularly relevant is a discussion of the devel-
opment and consequences of current social values in regard to individualism,
personal responsibility, competition, and individual success.

Chapter 2 turns to the microsocial level, focusing on individual social ac-
tors as they act and interact. This chapter presents an in-depth discussion of the
symbolic interactionism perspective in therapeutic applications. Drawing upon
important contributions from the works of George Herbert Mead, W. I. Thomas,
Robert Merton, and Erving Goffman, Hurvitz and Straus emphasize the social

act as the organizing concept of the sociocognitive, microsocial approach. They give two basic strategies for analyzing social acts: (1) establishing a context in which family members can be observed interacting with one another as well as with the therapist, and (2) examining family members' accounts as revealed privately to the therapist or in the presence of other family members. Specific processes are suggested for gaining practical understandings of family members' definitions of the situation. Reflective, analytic, and directed discussion techniques are outlined, as well as specific suggestions for implementing them. Of particular importance is a discussion of the importance of identifying how family members perceive themselves and other family members as well as how they perceive each other's perceptions of them. Detailed case examples illustrate the concepts and processes presented. Enlightening for those who work in clinical practice are practical outlines for handling first appointments and the reluctance to participate in therapy.

Chapter 3 also presents a general outline for practicing sociocognitive intervention. For example, it discusses how to encourage family members to establish new meanings that support individual and joint values and goals. Laudable is Hurvitz and Straus's recognition of the relevance and importance of established interventions, such as the cognitive techniques used by psychologists, and their descriptions of how to interweave those interventions with important sociological concepts.

Hurvitz's concepts of terminal, instrumental, and therapeutic hypotheses are clearly illustrated. The procedures outlined for facilitating therapeutic discussion, including the concepts of terminal and instrumental hypotheses, and procedures for guiding family members' generation of instrumental hypotheses are excellent.

Chapter 3, on working with families as social groups, delineates the process of working with families, including first contact with the therapist and the opening phase of family therapy when information is gathered through a naturalistic assessment process. Using actual cases drawn from Hurvitz's practice, the text differentiates problems, dividing them into personal limitations and interpersonal predicaments; family conflict, including disruptive conflict; and family crisis.

Chapter 4 turns to the process of family therapy. It emphasizes the opening phase of the sociocognitive therapy process, with a specific emphasis on utilizing a Four Questions Technique to make a naturalistic assessment. Therapy goals and limitations are also discussed, as well as the rationale and tactics for both individual and joint meetings.

Chapter 5 focuses on the change-inducing phase of therapy. Crisis management is stressed, and a three-stage process, (1) retrospective reconstruction, (2)

situational reconstruction, and (3) prospective reconstruction, is identified and described.

The change-inducing phase is continued in Chapter 6 with resolving conflicts and interpersonal predicaments as major topics. In addition, three major processes through which spouses or family members determine, establish, and maintain common meanings—decision-making, bargaining, and problem-solving—are presented.

The final stage in the change-inducing phase, overcoming personal limitations, is explored in Chapter 7, using techniques from behavior therapy, rational-emotive therapy and hyposuggestive procedures as well as relaxation and dramaturgical interventions associated with or derived from psychodrama or sociodrama. This chapter illustrates how the insights and techniques of other disciplinary perspectives can be creatively utilized within a sociocognitive approach. Also particularly informative are suggestions for self-management practices, homework, and encouraging each family member to act as a responsible change agent.

Finally, Chapter 8 describes the termination phase of therapy. Sections describe how to decide when to end therapy sessions, identify signs of progress, handle final appointments, and engage in post-therapy activities.

Overall, this book is a commendable contribution to clinical sociology in particular and to the therapeutic community as a whole. In the field of marriage and family therapy, it goes beyond systems theory to a framework that includes both the macro and micro bases and consequences of family problems. The theoretical discussions of the importance of societal factors in individual and family difficulties, as well as the critical significance of a symbolic interactionist standpoint, are exemplary. Paradoxically, case examples do not always demonstrate how societal factors or symbolic interaction concepts were utilized by the therapist in his understanding and intervention strategies. The book's emphasis on the family members as partners in the therapeutic process is also a significant contribution, as is the dual focus on overcoming personal limitations and helping the group reduce interpersonal difficulties. Even more important is the focus on how marital and family problems cannot be considered separately from other problems in society. Again, however, it would have been helpful to have these points demonstrated more clearly in case examples.

A final point is that although the book makes a major contribution from a sociocognitive standpoint, there is a startling lack of emphasis on the feelings and subjective experiences of Hurvitz's clients and the critical role that the extensive literature on the sociology of emotion could play in expanding upon and refining a sociocognitive approach. Unfortunately, while in most cases the work

points out relevant factors from other disciplines or subdisciplines of sociology, it downgrades contemporary emphasis on feelings. The challenge for future researchers, including practitioners, will therefore be to integrate this important "emotional" area into the sociocognitive approach.

Munchhausen's Pigtail or Psychotherapy and "Reality," essays and lectures by Paul Watzlawick. New York: W. W. Norton, 1990. 286 pp., $19.95 clothbound.
Gladys Rothbell
State University of New York at Stony Brook

When I was a small child, I used to follow my mother about and respond to everything she said by asking, "Why?" Eventually, her patience would wear thin and she would snap at me with "Vy, vy, vy, Enough already with vy!"

These long-forgotten early memories were evoked upon reading Paul Watzlawick's book, which also emphatically rejects the "why" question, albeit for different reasons. In *Munchhausen's Pigtail* the author argues that as clinicians seeking to effect change in human interaction, we have been asking the wrong question. By asking "why," we sought to identify traumatic events in a person's past which could provide insights into his or her present behavior. The idea was to assist the client to bring long-buried past incidents to consciousness. In this traditional psychodynamic approach we assumed that the resulting insights represented liberating revelations of "truth," which could lead to transformations in behavior and in interpersonal relationships.

In reality, the author argues, this process often proved to be long, tedious, and unsuccessful. He suggests a radical departure from this traditional approach, based on a reexamination of its underlying premises. Specifically, he challenges three central tenets of the traditional psychodynamic model. He challenges the assumption of linear cause and effect, suggesting instead a cybernetic model. He challenges the treatment of a single individual when the problem is a troubled relationship. (The improvement of troubled relationships is his central focus in this book.) Finally, he challenges the assumption that treatment necessarily entails a search for truth—an answer to the "why" question.

According to the author, the mission of psychotherapy (and indeed of science in general), is much more pragmatic. Indeed, pragmatism is the essence of his approach to the transformation of relationships. Accordingly, he suggests observation and analysis of the patterns of interaction in a relationship for the purpose of uncovering the underlying constructed realities of the participants. He further suggests examination of these constructed realities—definitions of the situation—for the purpose of determining promising changes in the constructs.

This is a radical departure from traditional psychodynamic approaches because it does not rest on the idea of science as a search for truth. Indeed, the author specifically rejects that idea and argues that it is not important whether a client's perception of reality is true. What is important is that it works!

The author is not dealing here with distortions of what he calls first-order reality. (First-order reality involves objective descriptions of such things as the colors of the flag or of Tom Sawyer painting the fence white.) He is dealing with second-order reality, which involves the attribution of meanings to these objective first-order realities. Attribution of meanings calls for assessing what the flag stands for or whether painting the fence was actually a privilege or a punishment.

Human relationships—in contrast to objects which exist in their own right—do not lend themselves readily to consensus regarding their properties. Interpersonal reality is not real in the same sense that objects are. It is a reality of the second order. A relationship has its reality only in the perceptions of the partners, and even that reality may be only partially shared by them. As Jessie Bernard has noted, there may be significant differences between his marriage and hers.

The role of the therapist, the author suggests, is not only to ascertain the separate constructs of the parties to a relationship, but also to analyze the cybernetic interaction between the component constructs. The therapist's goal is for the clients to adopt a harmonious *combination* of constructs. The therapist should not be concerned with *why* people adopt particular views of reality, but rather with whether those views are causing pain. If they are, the therapist should assist clients to adopt less dysfunctional combinations of constructs. This does not necessarily mean less distorted constructs of reality—only less destructive ones.

This approach suggests a clinical application of the Thomas theorem, which observes that if people define situations as real, they are real in their consequences. Watzlawick carries that idea a step further, however. He argues that since beliefs can provoke real consequences, then it is possible to decide in advance on the consequences we seek and then choose those beliefs—constructs of reality—definitions of the situation which promise to eventuate in the desired consequences.

The author's provocative ideas raise larger questions beyond the realm of therapy and relationships. On the one hand, there is something attractive about a model which emphatically eschews the embrace of cosmic "truths." Human history is already sufficiently strewn with the corpses of the victims of ideologues carrying the banner of "truth" to infidels, heathens, heretics, and dissidents.

On the other hand, there is something disquieting about planning a deliberate, conscious, disregard for "truth." It raises the idea of giving up the fight

against nothingness, surrendering the quest for meaning. The author recognizes the problem, but does not ultimately come to grips with it.

He draws on Schopenhauer to make the case that sense and order in the world are constructed by an act of human attribution and only then rediscovered "out there" as supposed facts. What we call reality, he argues, is not what we discover but what we create. Once a world picture has been posited, a reality is constructed and the unconscious creators are trapped within that image. Their perceptions are bounded by that framework.

Those who suffer emotionally suffer not just from reality but from their own pictures of reality. Essentially, human sufferers (individuals, couples, families, or even nations) are trapped in their own world pictures, playing a game-without-end. This game has no rules for changing the rules and no rules for ending the game. It creates a vicious cycle without readily discernable escape routes. Nevertheless, Watzlawick argues, escape attempts are imperative:

> If the sufferer should ever succeed—be it spontaneously or through therapy—to escape the apparently all-encompassing framework of his reality, it is the result of a remarkable and astounding leap out of his framework, a pulling oneself up by one's bootstraps that rivals the trick of Baron von Munchhausen. I would even go so far as to maintain that the essence of effective therapy lies in the bringing about of this leap. . . . (184)

In the final analysis, the critical ingredients of interpersonal reality are the answers we create to the questions we *choose to pose*. The consequences of our choice of questions are profound. The author persuasively challenges us to abandon the "why" question—the search for truth—and to reconsider our perceptions of interpersonal reality as well as our favorite strategies for therapeutic intervention.

Role Change: A Resocialization Perspective, by Melvyn Fein. New York: Praeger, 1990. 203 pp.
Novella Perrin
Central Missouri State University

The field of clinical sociology has stood on the periphery of mental health practice for decades. With the publication of *Role Change: A Resocialization Perspective*, clinical sociology may not only move into the psychotherapy arena, but may in fact change the way more traditional disciplines view the client and the helping process.

The world of psychotherapy has belonged to the psychiatrists, psychologists and social workers, most of whom have focused on finding the personal defect of the individual seeking help and assisting him/her in "fixing" it. *The Cinderella Complex* by Collette Dowling, *The Wendy Dilemma* and *The Peter Pan Syndrome* by Dan Kiley, and *The Good Girl Syndrome* by William Fezler and Eleanor S. Field, are but a few of the more recent popular self-help books that have followed this same focus of identifying the personal defect and offering solutions. However, the focus of *Role Change* is not the personal defect but rather the relationships and roles in which the person is engaged. The currently popular codependency literature has acknowledged the importance of relationships but has not developed it in the same fashion or to the same extent as Melvyn Fein.

The basic thesis of the book is that personal unhappiness is caused by social role problems, and in order to relieve the unhappiness, dysfunctional roles must be changed. Dysfunctional roles are created in the socialization process and must be relinquished and new ones constructed to replace them. This relinquishment and reconstruction is the resocialization process.

The first chapter outlines the role perspective and identifies types of role problems. These include roles which were initially constructed incorrectly, roles which have become dysfunctional in a new social context, and roles which are dysfunctionally maintained. In order to correct these role problems, Fein identifies three levels of intervention—social support, socialization, and Resocialization. The level of intervention to be used is dependent on the amount of change that is attempted.

The discussion of roles, role scripts, and role failures in the second chapter may seem basic or repetitive to the trained sociologist. However, the last half of the chapter includes an analysis of the effects of coercion on roles that should not be overlooked. It is in this analysis of coercion that some of the most helpful insights are presented. This writer found the discussion of "repetition compulsion" (30–31) particularly useful. It became apparent that clients who continually fight the same battle (and who continually lose) are not psychologically defective; they simply are attempting to find a relationship in which they can win (just once). These clients are reenacting childhood power struggles where the power cards definitely were stacked against them.

Throughout the book there are constant reminders that the resocialization process is not easy for the client. Resocialization strikes at the basic role structure and change is both scary and painful. However, it is in Chapter 3 that the losses and accompanying grieving process are systematically presented. Although this third chapter indicates the resocialization process is difficult, it is

not until the fourth, fifth, and sixth chapters that the emotional, social, cognitive, and volitional impediments to the change process are identified and discussed.

The strength of the seventh chapter lies in its outline of the qualities and skills of a "good" clinician. These are not restricted to clinical sociologists practicing the resocialization perspective, but are equally applicable to all clinical practitioners. Some of these skills are more extensively discussed in the two following chapters in terms of roles a clinician might play in helping a client unblock emotions and renegotiate dysfunctional roles. Again, these ideas are not limited to resocialization practitioners. All clinicians may benefit from Fein's insights.

The book presents a solid theoretical base for the resocialization perspective. It then outlines the perspective and details the client's defensive emotional, cognitive, and social barriers to the process. It offers insight on abilities and skills the clinician should possess in order to use this paradigm as an intervention tool. It also includes brief vignettes for illustration. The book is solid in every aspect, yet this writer is concerned that it will not immediately be embraced by either the professional mental health community nor the readers of popular self-help literature. Although the resocialization perspective represents the best of many respected therapies and trends in a variety of disciplines, this convergence may not be positively viewed by all disciplines. Professional turf protection and professional jealousies may *delay* the use of this perspective. The tradition of "medicalizing" interpersonal problems has been adopted to such an extent that the new terminology and focus may *delay* the understanding of this perspective by the general population. Please note that this writer has underscored the word delay for both audiences. It is my opinion that the resocialization perspective may not *immediately* revolutionize psychotherapy, but in the coming decades it easily could be the newly accepted perspective in the helping professions. This book, therefore, becomes important reading for all mental health practitioners, not just sociologists.

The beauty of this book for sociologists is that it uses the very basic principles of the discipline. Yet it systematically organizes them so they have utility beyond the academic and policy arenas.

If you only read one book this year, this is *the* book to read. On a personal level, it will add to your knowledge and may change the way you practice sociology. On a professional level, it clearly establishes the resocialization perspective as a viable method to assist clients in changing dysfunctional behaviors. On a broader scale, it may change the way clinical sociology is practiced, viewed, and accepted by other disciplines.

Creative Self-Hypnosis: New Wide-Awake, Nontrance Techniques to Empower Your Life, Work, and Relationships, by Roger A. Straus, Ph.D. New York: Prentice Hall Press, 1989. 270 pp., $9.95.
Judyth L. Scott
California State University, San Bernardino

Creative Self-Hypnosis offers a refreshing alternative to more traditional behavior modification books. Rather than concentrating on when or why behavior occurs, Straus advocates changing one's behavior by "changing one's reality" (97). He encourages the reader to develop, through uses of the book's visual imagery techniques and exercises, his/her own personalized self-help program. The goal of the book, according to the author, is to facilitate empowerment. By employing the book's self-management strategies, one is able to ultimately "create" a more meaningful reality.

Straus, a clinical sociologist, is the author of the 1982 book *Strategic Self-Hypnosis*, and editor of the textbook *Using Sociology: An Introduction to the Clinical Perspective*. Straus has made good use of over a decade's experience in research, teaching and practice to develop the strategies used in his newest volume.

The book not only serves as a self-help tool for individuals or groups, but is a valuable practice tool for counselors, therapists and hypnosis practitioners as well. Professionals in both the behavioral and social sciences may find it a useful teaching aid. Thus, the book has varied utility.

The format of Straus's book is almost as important as the content. The volume contains an introduction, a section titled "How to Use This Book," and seven chapters. The order of the information is deliberate and sequential, as with any good training program. Self-empowerment skills are thus obtained in a step-by-step process, beginning with a chapter entitled "Self-Management." The proceeding chapters are "Mind Control," "Effective Action," "Strategic Interaction," "Positive Relationships," "Optimal Performance," and finally, "Creative Living."

Straus's methodology incorporates both indirect and cooperative strategies for implementing change. His indirect strategy involves simply acting in the changed way to achieve the reality one desires. This purposeful "acting" may be done alone or in a cooperative way, with the support of others. Throughout the book the author offers suggestions for using his strategies with teams.

Straus's book is filled with the ideas of the many scholars and practitioners who have influenced his work. These include Herbert Blumer's well-known symbolic interaction; Erving Goffman's strategic interaction, through which, Straus says, we can analyze how we as social actors "manage impressions and

elicit desired responses from our audience" (114); Nathan Hurvitz's instrumental hypothesis, which involves reframing one's reality from a negative to a positive belief in the ability to act and subsequently change one's circumstances; and Ron Lippitt's concept of resistance, in which we attend to those internal voices that abet our resistance to positive change, thus increasing our awareness of the voices of significant others inside us.

Many sociological concepts and ideas crucial to understanding the self are introduced, and Straus does so in an engaging, and often witty manner. Complementing these concepts are three types of self-help strategies—exercises, techniques, and key tactics. Together, these are integrated with the narrative and offer a unique self-improvement program.

Although Straus's strategies are designed to complement one another, each serves a different function and can be used alone. Thus, the reader may pick and choose those he/she finds most useful. Both the exercises and techniques, as their names imply, engage the reader in some form of activity.

Exercises usually involve visual imagery in which the reader focuses on some hypothetical, everyday occurrence. In one exercise, for example, after describing a tension-filled conversation between "Ken and Barbie" (143), the author asks the reader to visually recreate it so that a more positive outcome is achieved. Another exercise consists of imagining oneself successfully accomplishing a personal goal, and then recording the experience in a journal. Both these exercises heighten the reader's awareness of how best to "create" a successful situation in reality. While readers may find a few of the exercises tedious in length, most are fun and creative.

Techniques, though similar to exercises, are more general in content and act as "pep talks" that one gives oneself. The seven techniques may involve listening to a prerecorded or spontaneous script of one's own voice or another's. They embody what is meant in the book's title by a "wide-awake, nontrance" form of "creative self-hypnosis." A partial example of the script form technique one reads:

> . . . rediscovering the feelings of power and calmness, peace, energy, and strength . . . you find yourself awakening now . . . your deep power awakening . . . your abilities awakening. . . . your true potential awakening . . . becoming your own . . . to focus and apply and use. . . . (35)

Key tactics are more specific in focus than either exercises or techniques. In them, Straus offers concrete directions to strategically create one's reality. Key tactic number twenty-two, for example, suggests "To optimize your performance,

play with it; try never to repeat yourself exactly" (224). Straus's innovative key tactics encourage the reader to be equally creative in his/her performance.

A problem for even the most dedicated reader may be the time-consuming nature of most of the exercises, coupled with the frequency with which they occur. A great many of the exercises require either visualization, journal writing, or both. The fifth chapter, for example, includes ten exercises, along with creative self-hypnosis strategies. These can take hours, depending on the individual. Furthermore, Straus suggests that to gain the most benefit from the book, one should repeat the exercises. Persons desiring a self-help program for problems such as impatience, inability to complete tasks, or procrastination, will be put off by Straus's book before they begin to learn the strategies necessary to combat their problem(s).

In spite of the difficulty some readers may have in working on all the exercises, their diversity and number offer readers, whose needs may differ, a variety of choices. And, as previously mentioned, the volume is designed so that the reader may pick and choose those exercises that meet his/her needs.

The sociological theory contained in Straus's book lends itself well to an understanding of the practical strategies he suggests. It is my belief that the strategies in *Creative Self-Hypnosis*, when applied with some consistency, can lead to positive change in the quality of one's life. This book is innovative, optimistic and original in its approach to empowerment.

AIDS and the Allied Health Professions, edited by Joyce W. Hopp and Elizabeth A. Rogers. Philadelphia: F. A. Davis Company, 1989, 311 pp.
The Psychological Aspects of AIDS: An Annotated Bibliography, edited by Paula L. Levine, John G. Bruhn, and Norma H. Turner. New York: Garland Publishing, Inc., 1990. 576 pp., $70.00 clothbound.
C. Allen Haney
University of Houston

These two very different works have in common a concern with AIDS. Each, however, was designed to serve markedly different purposes. The first, *AIDS and the Allied Health Professions* is a collection of eleven chapters, each designed to give, in overview fashion, the necessary information to prepare and advise those in the health professions of the challenges, difficulties, and precautions to be encountered in the treatment of persons with AIDS and related diseases. Perhaps more importantly, this book sets forth the presently recommended techniques for the safety and comfort of patients and professionals alike. Chapters are, of necessity, relatively brief, easily understandable, and accurate as far as they go, taking into account the fact that each chapter addresses a topic that could

easily require a book-length manuscript. Of value is the fact that each chapter begins with a statement of the learning objectives and addresses each of these objectives. There is a good deal of unevenness in the writing style and scope of the chapters. Regrettably, one of the weakest of the chapters is that which deals with the psychosocial aspects of AIDS. Perhaps this material could have been better presented if separate chapters on psychological and sociological aspects of AIDS had been addressed. This would not necessarily have added more than thirty to thirty-five pages to the work.

It is unlikely that this work would be the sole text for a course. It would, however, make an excellent supplement to a course dealing with psychosocial aspects of health care and health care services. It would serve as a valuable text for a "short course" or a continuing education course as a self-contained topic.

The second work, *The Psychosocial Aspects of AIDS: An Annotated Bibliography,* is an extremely accurate, comprehensive, and valuable research tool. This is particularly true for the scholar just beginning to conduct research in this area. The six sections are well organized and apparently thorough. Clearly, a work such as this that deals with a phenomenon about which so much research is ongoing is destined to become dated almost before the ink is dry. Nevertheless, this work can be of tremendous value in bringing the researcher "up to speed" in this voluminous and rapidly expanding literature.

Of the works with which I am familiar and from reviewing a sample of the citations with which I was not familiar, the citations were accurate and, perhaps more importantly, the annotations rightly described the content and context of the work, even if the author(s) used titles that did not. It would have been of greater value if the list of bibliographic data bases used had been included and if "key words" used in computer searches for compiling this bibliography had been included.

Inhuman Relations: Quality Circles and Anti-Unionism in American Industry, by Guillermo J. Grenier. Philadelphia: Temple University Press, 1988. 323 pp., $34.95 hardbound, $16.95 paperbound.
Anthony J. Riech
California State University, San Bernardino

This is a story of a social scientist coming of age. It tells of Guillermo Grenier's experiences at the Ethicon subsidiary of the Johnson and Johnson Company in Albuquerque, New Mexico. Grenier's experiences took place during a nine-month period while he was an unpaid graduate assistant to Ethicon-Albuquerque's social psychologist. Grenier's objective was to collect data for his graduate research on teams in the work force, which is how Ethicon-Albuquerque

had divided its labor. During this time the Amalgamated Clothing and Textile Workers Union tried to establish itself at Ethicon-Albuquerque. The author eventually became a pro-union activist.

Grenier's book has eight chapters. The book did not flow well at first, but the last chapters were more "story-like" and easier to read. The first three chapters described the company's image and the management's view of teamwork. They also introduced the use of quality circles and the concept of "new humanism." A quality circle (QC) is a small group of workers, usually led by a foreman, who "shares with management the responsibilities for locating and solving problems of coordination and productivity" (4). New humanism was defined as "a vision of unity, cooperation, purpose, and inspiration, of managerial wisdom operating unfettered in an expanding union-free utopia" (xiii). The company planned to let the workers participate in this new humanism by following Japan's idea of the "quality circle."

The next four chapters presented the beginning of union organizing and the company's strategy for dealing with the union. Grenier explained the psychological tactics and firing practices used by the company to control union support, along with descriptions of how the employees worked against themselves by the company's use of participatory (QC) management.

In the last chapter the author reviewed the history of participatory management in America, and examined Ethicon-Albuquerque's use of human relations. Grenier was aware of the QC approach before he began his research and thought it was a good program, for both industry and labor. His attitude changed as he became involved with the company and attended some QC meetings. He came to realize the QC emphasis was on increased productivity and that any improvement in the quality of work life for the employees was incidental. Grenier reports that Johnson and Johnson publicly said it was not anti-union, but, in fact, the firm had a covert plan of action to keep the union out. The QC was the main weapon. The company planned to use the workers themselves, through participation, to bust the union.

The author noted that forms of control could be found throughout the QCs at Ethicon-Albuquerque, and there were three interrelated methods that could use participation as a form of control. First, by having the workers involved in a QC, they were more apt to see things from management's point of view. Second, workers had some power of decision, but management made sure the workers' decisions only dealt with unimportant areas of the workplace. An example of this form of control was to encourage peer pressure in the groups. The workers felt they had a voice in the hiring and firing process of their peers. This obscured the fact of who actually made decisions. Third, management had set up the QC to intimidate workers who seemed not to be doing what management considered

to be good for the group. Favors were granted to workers who would "rat" on their fellow QC members who mentioned the union during working hours. Working conditions became very difficult for pro-union workers, "time off" became almost impossible to get, and their breaks were monitored to the second.

The QCs were also a form of control because they fragmented the work force. They promoted a sense of belonging to the small group, but decreased the feeling of membership in the larger community of the plant. These small teams made it easier for management to recognize deviants. Even though the work force was fragmented, the power structure of management remained intact and in control.

Toward Grenier's last month at Ethicon-Albuquerque, the workers voted to determine if the union would be allowed to come into the plant. The author gave some examples of his personal experiences and feelings of that time. Grenier said he was now actively involved in pro-union activities, yet continued to gather data for his research. The company had become suspicious of him. He reported that as a result of his pro-union participation, he received threatening phone calls, his files and notes were subpoenaed (illegally), and his house was watched for weeks. On two occasions he and his family were forced to leave their home because of threats.

Grenier mentioned that stepping outside his role of a neutral social scientist bothered him. I was surprised by his reaction. I also do not understand why he appeared so unprepared to deal with, or was taken aback by, the tactics of a capitalist organization's manipulation of workers. Grenier's training should have made him more aware of the workings of the personnel system. This naivete may reinforce the idea that academia is an "ivory tower" and perhaps does not prepare some of its students to confront the realities of the outside world.

Grenier's book will be a useful tool for educating social scientists about the relationship between sociological practice and academic sociology. I recommend this book for students, teachers, and practitioners who are concerned about management and labor issues and those conducting research on organizational programs.

The following review was originally published in volume 8 of CSR and is reprinted here with author corrections.

Personal, Marital, and Family Myths: Theoretical Formulations and Clinical Strategies, by Dennis A. Bagarozzi and Stephen A. Anderson. New York: W.W. Norton, 1989, 321pp., $32.95 cloth. **Family Evaluation,** by Michael E. Kerr and Murray Bowen. New York: W.W. Norton, 1988, 400pp., $29.95 cloth.
Harry Cohen
Iowa State University

In *As You Like It*, Shakespeare wrote that "All the world's a stage" and "all the men and women merely players." In *Using Sociology*, edited by Roger Straus, I stated my dramaturgical equation:

$$Act \longrightarrow re\text{-}act = inter\text{-}act\text{-}ion$$

The roles we play, based on scripts set into the mind, lead our audiences to re-act our acts based on their own perceptions, inner scripts, and roles. They and we are "on stage," acting, reacting, and interacting. When maids come together "on stage" in marriage, each brings a repertoire of scripts, acts, and expectations. These meld and often enough also lead to conflict. This is my dramaturgical "stage-setting" for the book *Personal, Marital, and Family Myths* by Drs. Bagarozzi and Anderson.

Dr. Dennis Bagarozzi is a psychotherapist in private practice in Atlanta and Athens, Georgia. Dr. Stephen Anderson is associate professor and director of the marital and family therapy training program at the University of Connecticut. They have written a clinical analysis of personal and family myths. Changing myths as mental scripts changes behavior based on them, affecting roles on stages of life. Audiences tend to react differently, affecting the interactive life show.

One oversimplified example from the Bagarozzi-Anderson book: A man's relationship to his mother and wife is characterized as "a moth drawn to a flame." He does not trust people. A moth drawn to a flame is powerless and is burned. He is drawn to his wife's flame but fears (his mistrust of people) the burn and withdraws. The wife reacts. The marriage is locked into a show with sad scenes. The therapist inspired the vision that the couple could live more like "two peas in a pod." Here people are together and separate. They are together for warmth and separated to avoid becoming inflamed. This new image improves the marital interaction (63).

This "together and separate" theme is a key element of the "differentiated self" as presented in the book *Family Evaluation*, by Michael Kerr and Murray Bowen. "Drawn to a flame" represents the uncontrolled emotional reactivity that Kerr and Bowen show to be the state of the "undifferentiated self," the self which has the most problems because of emotional fusion to other people's anxiety and provocations. The undifferentiated are the "identified patients" who suffer by acting out the anxiety of the group.

Bagarozzi and Anderson focus on constructing new myths for clinical improvement. The Bowen model of change focuses on developing a systemic understanding of the family scene to shift roles toward greater differentiation. People are taught to stop blaming others. Behavior is seen as the consequence of systemic multigenerational processes (254–55). The Bowen method is to "focus

on changing self rather than on trying to change others." It is necessary to develop an "ability *not* to react to relieve the anxiety of the moment" (79). "Focus on self, an awareness of the emotional process in the family, and the ability not to be governed by anxiety and emotional reactivity are all components of a long-term effort to increase one's level of differentiation" (79n.19).

Some people think a myth by definition is a fake and constraining. Bagarozzi and Anderson take exception to this view. A myth may seem nonsensical because it is made up from nothing. I add so is everything else made up, if one adopts a constructionist, attributional view of how reality is created. A myth may be made up but functions as an ordering device, as does perceiving the importance of sports or other social constructions of reality. "It is our contention that family myths are universal and not necessarily pathological. Their functionality can be determined only by assessing the degree to which they contribute to or curtail the growth and development of each family member and the family system as a whole" (2).

Drs. Bagarozzi and Anderson, writing to set the framework for their book, at the same time offer a summary of major points of Bowen's theory presented with Kerr in *Family Evaluation*:

> [We] are born into and raised by a family group from which we must separate and individuate. As we attempt to master each successive developmental task, to disentangle thoughts from feelings [major aspect of Bowen's differentiated self], to develop a true self (as opposed to a false or pseudo self), to free oneself from the enmeshed confines of an undifferentiated ego mass...[the authors correctly credit Bowen for these terms], to achieve self-realization (Jung...), and to actualize our inherent potentials (Maslow..., Rogers...), we create our own personal mythology, complete with attendant rituals, rites, and taboos. Our individual struggles with differentiation and self realization can be conceptualized as a personal recapitulation of our primitive ancestors' struggles to free themselves from the confines of the participation mystique and to separate the self from an all encompassing, preconscious existence in the primal group (Neumann...) (3–4).

Drs. Bagarozzi and Anderson write that in their clinical practice they have often seen a client taken over by the power of personal mythology. Such a person "seems possessed, driven, compelled to behave in a particular fashion. As if in a dream or surrealistic passion play, the person goes through various ritualistic behavior patterns in an attempt to relive and resolve some conflict or to master a particular life task" (4). I see the same process in the collective behavior of

groups and whole societies. Fascist groups and intemperate ideologies and be-
havior even in our democracy and academic world share compulsions, ritualistic
thinking and regression (toward the immature primal past).

Individuals and groups share a recursive myth-making. Bagarozzi and An-
derson explain that it is impossible to separate an individual's personal myths
from those of family, community and culture. They focus on understanding

> personal myths in terms of how they affect relationships with signifi-
> cant others in the context of marital/family systems. Individuals, cou-
> ples and families are seen as actively selecting and adopting, as their
> own, those cultural myths whose various components, symbols, ritu-
> als . . . have meaning and importance for each family member and the
> marital/family system as a whole. These cultural myths are modified
> and reworked by the individual in ways that fit into his/her personal
> mythology (5–6).

Bagarozzi and Anderson determine profiles of their clients through var-
ied questionnaires. One is called "Spousal Inventory of Desired Changes and
Relationship Barriers." This is used to help evaluate the perceived fairness of
the social exchange dimension of the marriage, providing clues to relational
dysfunctions (96).

Many fascinating case studies are presented. Equally fascinating are exam-
ples of how life stories are changed. One method is to have clients state their
favorite stories and characters from novels, movies, or television shows. One
chose the movie based on Jean Auel's novel, *The Clan of the Cave Bear*, which
is also a story of the quest for differentiation. Clients design roles and write
new scripts for characters who may be seen to represent themselves and family
members. While doing this they can experiment with new possibilities in their
families and lives.

In our way we are all as Shakespeare said, "players" on the stage of life.
Drs. Bagarozzi and Anderson show that while we are players we do not have
to be puppets. We can be players and script writers, directors and producers at
the same time.

In their powerful book on "the role of the family as an emotional unit
that governs individual behavior and development," Michael Kerr and Murray
Bowen show that for some people it is difficult to play on stages of life without
being pulled as puppets by strings of the group. The group pulls and they "act
up," "acting out" the group processes. This type is called the "undifferentiated
self." The "differentiated self" is a social player but not a puppet. The book has
implications for all social groups and is not limited to the family.

No one, not even the authors, is totally differentiated. Everyone has a basic level of differentiation which comes from a process dating across generations. It is not someone's fault to have a certain eye or hair color; nor is it a person's fault to have "inherited" a lower level of differentiation. If people and life conditions do not press, a person may have a good functional differentiation level, performing with few problems. But when life constrains, a person with a low basic level of differentiation falls in functional differentiation level and tends to suffer more problems than one with a higher level (97–107). Those lowest in differentiation may engage in violence, suffer psychoses, or become physically ill in response to group pressures. They have difficulty separating self from others.

Sociologically important is the authors' observation that society itself has become more undifferentiated. We see this in varied social pathologies. Much of our democracy is based on attempts to achieve more differentiation. A free press, rights to free speech, separation and balance of governmental powers, separation of church and state, all aim toward "separate while together." However, we are subject to societal regressions: intemperate attacks for divergent views, unyielding emotional ideologies which are based on blaming others and hate, mutual and unending intergroup provocations and emotional "fusion," gangs, and addictions. "The lower the functional level of a society, the greater the incidence of 'social symptoms' such as a high crime rate, a high divorce rate, an incessant clamor for 'rights,' and a notable neglect of responsibilities" (334).

Social regressions are like infectious epidemics. Not everyone acts out antisocial behavior, but as the level of anxiety and emotional reactivity in the group increases the larger the number of group members who "fall" and act out. This "infects" still others.

> Individuals and families with higher levels of differentiation . . . are better able to avoid the pitfall of blaming others [blaming keeps people enmeshed and provides justification for getting even] and are less influenced by the pressures of a frenzied group. Entire societies [as are families] can be conceptualized as emotional systems. When anxiety mounts in the society, the average functional level of differentiation decreases and the society goes through a period of regression. [There is] more behavior by certain subgroups that impairs the functioning of other subgroups, and more symptoms of all types (251n.29).

The family process transmitting levels of differentiation works as follows: People of common levels of differentiation tend to marry. Some of their children tend to have similar levels of differentiation-undifferentiation, and some

siblings are more or less differentiated. Those siblings less differentiated tend to marry similar partners and have children, one or more of whom are even less differentiated. These also marry on an equal level of differentiation. After several generations this process yields a highly undifferentiated family and one member who is so fused to the group anxiety that (s)he acts out the provocations of the group (ch. 8).

Murray Bowen, M.D., is clinical professor at Georgetown University Medical Center, and director of the Georgetown University Family Center. He was a pioneer in the development of family systems theory and in research and treatment of schizophrenia. Michael Kerr, M.D., is clinical associate professor at Georgetown University Medical Center, Washington, D.C., and director of training at the Georgetown University Family Center.

Dr. Bowen has written an epilogue to the book in which he states his "40-year odyssey in developing family systems theory and therapy, also known as the Bowen theory" (339). True to the theory of differentiation, Dr. Kerr wrote the major portion of the book without Bowen's knowledge of its content. They are intellectually linked and remain separate in their scholarly development.

A brief book review cannot adequately cover the impact, wisdom, depth, beauty and importance of the Kerr-Bowen book.

Resumés en français

Le rôle du sociologue praticien dans la programmation de la promotion organisationnelle de la santé

Linda R. Weber

Dans cet article, les rôles du sociologue sont examinés étant donné qu'ils s'appliquent au domaine en pleine expansion de la promotion organisationnelle de la bonne santé. Les programmes de promotion de la santé comprennent une combinaison d'activités éducatives, organisationnelles et écologiques conçues pour soutenir un comportement orienté vers une bonne santé dans le cadre du travail. De tels programmes comportent habituellement des programmes de perte de poids, des cours d'aérobics, un contrôle de la tension, etc. Théoriquement, les idées de Mead et de Becker sont étudiées comme une approche à la compréhension des comportements par rapport à la santé. Méthodologiquement, l'utilisation de l'évaluation des besoins et des outils d'évaluation fournissent des informations complètes pour le développement d'un programme spécialement adapté à répondre aux besoins d'une organisation. Finalement, le sociologue clinique, en tant que praticien, peut travailler à créer des interventions programmées à réussir dans le cadre du travail. Le domaine de la promotion de la santé fournit un nombre de rôles parmi lesquels les sociologues pourraient trouver un emploi viable.

Troubles de la personnalité ou problèmes de négociation de rôles?

Melvyn L. Fein

Parmi les troubles de la personnalité définis par le DSM-III le DSM-III-R, beaucoup sont en fait des "problèmes de négociation de rôles." Sans de justes négociations orientées vers la résolution du problème, il est difficile de bâtir un mode de vie satisfaisant. Ceci est vrai, par exemple, pour les statégies passives-

agressives et histrioniques, et, peut, si on ne reconnaîtpas comme tel, nuire à l'efficacité des interventions cliniques.

L'apparition d'une sociologie clinique américaine: les premiers cours

Jan Fritz

Cet article décrit les premiers cours de sociologie clinique offerts par l'Université de Chicago, l'Université de Tulane, l'Université de New-York et Antioch College, ainsi que le projet pour un département de sociologie clinique à l'Université de Yale. L'auteur examine les raisons pour lesquelles les tout premiers cours de sociologie clinique ne furent pas institutionnalisés.

Consacrer sa vie à la sociologie humaniste

E. Briant Lee et A. McClung Lee

Elizabeth Briant Lee et Alfred McClung Lee décrivent leurs milieux familiaux, leur dévouement aux valeurs humaines et leur intérêt à alléger les problèmes sociaux. Les auteurs examinent les organisations de sciences sociales humanistes fondées par eux qui reflètent leurs valeurs.

Sociologie clinique et religion

C. Margaret Hall

Bien que la religion n'ait généralement rien à voir avec les principaux problèmes qui se présentent aux cabinets des thérapeutes laïques, les croyances et les valeurs religieuses peuvent exercer une forte influence sur le comportement et sur les progrès cliniques des clients. Pour cette raison, des connaissances sur la religion et son impact peuvent être utiles dans le travail d'intervention.

Trois dossiers montrent comment utiliser la sociologie de religion en tant que ressource substantive dans la sociologie clinique et l'exercice de la sociologie. Dans cet article, la religion est définie comme un système de croyances aux valeurs confessionnelles, sectaires ou laïques, et qui explique les phénomènes naturels et surnaturels.

Comme le concept d'un être suprême est central à la plupart des systèmes de croyances occidentaux, les perceptions des trois clients de leurs relations avec un être supérieur sont examinées. Leurs concepts de Dieu sont utilisés pour démontrer le proessus par lequel les stratégies cliniques peuvent rendre plus significatifs les choix de valeurs laïques et religieuses des clients, et augmenter leur

prise de conscience des conséquences qu'entrainent des croyances spécifiques sur leur comportement quotidien.

Ces trois exemples cliniques sont basés sur des données de vies entières de modèles contrastés de comportements résultant de fidélités individuelles à différents systèmes de croyances religieuses. Ces contrastes sont résumés comme modèles de "Déférence/Fatalisme," "le Moi en tant qu'Egal de Dieu," et "Coassocié avec Dieu Tout-Puissant." Il est suggéré que la sociologie de religion peut conseiller de manière effective des principes et des stratégies pour l'intervention clinique, ainsi que renforcer et enrichir les propositions fondamentales de la sociologie clinique.

Intervention constructive dans les conflits en Afrique du Sud: quelques leçons

Hendrik W. van der Merwe et Andries Odendaal

Historiquement, l'Afrique du Sud a manqué d'une culture de confiance dans la négociation en tant que méchanisme de compromis dans les conflits. Durant les mesures de sécurité à l'époque de P.W. Botha dans les années 1980 et la polarisation consécutive, les concepts tels que la négociation et la médiation étaient vus avec suspicion dans divers miieux. Cependant, paradoxalement, la législation du travail introduite en 1979 promouvait les pleins pouvoirs noirs, ce qui devait mener à des perspectives améliorées de négociation significative et rendre la médiation acceptable dans la solution des disputes ouvrières. Simultanément, les agitations des municipalités au milieu des années 1980 menèrent aussi à des négociations entre noirs et blancs au niveau local. Il fut déterminé au niveau politique national que, alors que le moment n'était pas propice à la médiation, la facilitation discrète en tant que forme d'intervention plus acceptable ouvrait en fait la voie à la percée politique de 1990. Le discernement développé pendant cette période mena à la formulation d'un certain nombre de principes de communication, et inclut la réconciliation d'options apparemment opposées telles que la négociation et la contrainte, l'impartialité et l'intérêt, des pas progressifs et des buts radicaux.

Combiner la sociologie et l'épidémologie: les premiers soins orientés vers la communauté dans un comté rural montagnard

Thomas Plaut, Suzanne Landis, et June Trevor

Les Premiers Soins Orientés vers la Communauté (PSOC) concentrent leur attention sur la communauté en tant que "patient" et impliquent ses habitants dans un processus de discernement des besoins médicaux et dans l'action à

entreprendre. L'accentuation des PSOC sur la participation de la communauté donne l'occasion au sociologue de créer des instruments pour la participation des résidents dans l'évaluation des besoins médicaux et des interventions qui s'en suivent. Cet article décrit le rôle de la sociologie dans le programme des PSOC dans un comté rural des Appalaches fondé par la Fondation W.K. Kellogg. Quelques 41 interviews de groupes représentatifs furent utilisées pour toucher plus de 416 habitants. Les résultats de ces interviews furent combinés avec les données épidémologiques et celles du recensement, et transmises à un Conseil Consultatif Communautaire composé de 27 membres, où des techniques soit disant de groupe furent utilisées pour développer une liste des besoins prioritaires et des interventions conséquentes. Deux interventions commencèrent en automne 1990. L'une est un programme dentaire de prévention des caries pour les écoliers. Le deuxiéme implique la formation de "conseillers sociaux profanes" pour travailler avec les parents de nouveaux-nés dans un effort pour améliorer la santé infantile et le rôle joué par les parents.

Explication du comportement de délinquence parmi les adolescentes: le contrôle social interne et l'association différentielle

Linda P. Rouse et Raymond A. Eve

    Quatre-vingt dix jeunes filles participant à un programme thérapeutique conduit en plein air ont complété des questionnaires dont les indexes comprennaient les problèmes scolaires, les activités sexuelles, l'utilisation de drogues et d'alcool, les actes de violence, les infractions à la propriété majeures et mineures, ainsi que divers délits. Les mesures de contrôle social interne étaient *l'attachement* aux parents et à l'école, *la responsabilité* par rapport aux buts éducatifs, *le dévouement* aux devoirs scolaires, *les croyances* au sujet de l'utilisation de drogues, et le respect de la loi. Des questions sur *le comportement des amis* mesuraient l'association différentielle. Cet article examine l'influence combinée du contrôle social interne en tant que barrière à la déviance et de l'association différentielle en tant qu'incitation à la déviance. Les théories utilisées précédemment pour expliquer la délinquence de jeunes garcons réussissaient généralement bien à identifier les correspondances du comportement en dehors des normes parmi ces jeunes adolescentes, bien que les résultats variaient selon les différents types de déviance considérés. Les auteurs traitent des implications de ces résultats pour le développement d'un programme.

Est-il vraiment important de développer de nouveaux systèmes de distribution des services aux personnes agées victimes de mauvais traitements?

Mary C. Sengstock, Melanie Hwalek, et Carolyn Stahl

Les pressions politiques imposées aux agences sociales demandent très souvent l'introduction de modèles alternatifs de distribution de services. Cependant, l'efficacité de tels modèles théoriques est problématique. Jouent-ils un rôle important dans la détermination des types de services fournis, dans leur efficacité, ou dans la faç on dont ils sont fournis par les agences? Ou bien les agences fournissent-elles des services relativement similaires, quelque soit le modèle? Cet article fournit une analyse des services fournis aux personnes agées victimes de mauvais traitements selon deux modèles théoriques différents: un modèle légal (avec deux variantes), et un modèle de distribution intensive des services. Les programmes variaient également par région, avec deux en zone rurale et deux en banlieue. Cette étude fut facilitée par le Département du Troisième Age de l'Illinois, avec des données recueillies sur 204 cas de mauvais traitements infligés à des personnes agées en 1986. Les types de mauvais traitements incluaient les mauvais traitements physiques et sexuels, la réclusion, la privation, la négligence, la négligence de soi et l'exploitation financière. Les résultats ne révélèrent aucune différence entre les modèles des services fournis ni dans l'aboutissement de ces cas. Des suggestions sont avancées en ce qui concerne les raisons de cette découverte et les autres facteurs qui ont peut-être joué de plus grands rôles.

L'obésité et la sociologie alimentaire: un modèle pour faire face au stigmate de l'obésité

Jeffery Sobal

La sociologie alimentaire utilise les théories et les méthodes sociologiques pour étudier et influencer les modes d'alimentation, les habitudes alimentaires et la nutrition. L'obésité et la perte de poids sont d'importants sujets de la sociologie alimentaire, et la stigmatisation de l'obèse est d'un intérêt de longue date. La plupart des études sociologiques passées n'ont fait que décrire la stigmatisation, plutôt que de développer des moyens d'y faire face. Un modèle pour faire face au stigmate de l'obésité est présenté dans cet article. Ce modèle comprend quatre composants: la Reconnaissance, la Préparation, la Réaction et la Réparation. La reconnaissance implique la prise de conscience du stigmate de l'obésité et la compréhension de la stigmatisation. La préparation implique une anticipation du fait que la stigmatisation peut se présenter dans des cadres spécifiques ou venir de certaines personnes, ainsi qu'une prévention de ces actes stigmatisants.

La réaction implique des techniques à effet immédiat et permanent pour venir à bout d'un acte stgmatisant. La réparation implique la récupération de la stigmatisation et des tentatives de restitution et de réforme des actions stigmatisantes des autres. Ce modèle utilise une perspective sociologique pour développer des stratégies pour venir à bout de la stigmatisation, ce qui diffère d'un modèle médical pour faire face à l'obésité. Ce modèle sociologique pour aider les gens à affronter le stigmate de l'obésité peut également être utile à d'autres types de stigmates.

Définitions socio-légales de la famille

Jean H. Thoresen

De récentes décisions prises dans des cas de législation sur la famille suggèrent que certains tribunaux sont près à élargir la définition judiciaire de la famille, et à créer ou accepter une définition qui étend la notion traditionnelle de ce qui constitue une "famille." Ceci donne aux sociologues la possibilité de travailler ou de se coordiner avec le système légal en redéfinissant la famille pour fournir un concept plus large que les tribunaux pourraient ensuite appliquer.

SOCIOLOGICAL PRACTICE ASSOCIATION:

A Professional Organization of Clinical and Applied Sociologists

The SOCIOLOGICAL PRACTICE ASSOCIATION, founded in 1978 as the Clinical Sociology Association is a Professional Organization of Clinical and Applied Sociologists. Members include organizational developers, program planners, community organizers, sociotherapists, counselors, gerontologists, conflict interventionists, applied social science researchers, policy planners on all levels including international practice, and many others who practice, study, teach or do research by applying sociological knowledge for positive social change. The Association's value orientation is humanistic and multi-disciplinary.

Benefits of Membership in The Sociological Practice Association

- Receive *Clinical Sociology Review,* the annual journal of the Association
- Receive the *Practicing Sociologist* newsletter four times each year
- Take part in association sponsored training conferences and workshops at reduced rates
- Work on a committee and be eligible for membership on the SPA Executive Board
- Participate in the SPA annual business meeting
- Work on any of a variety of issues that may interest you such as credentials, curriculum, training, ethics, membership or the annual program
- Be listed in the SPA Membership Directory
- Be eligible to apply for certification as a Clinical Sociologist
- Be part of a dynamic and significant movement in the social sciences
- Work with others toward a relevant sociology for the 1990s

For more information and a membership application, please contact Dr. Elizabeth Clark, Executive Officer, Department of Patient and Family Counseling, Albany Medical Center, New Scotland Avenue, Albany, NY 12208.