Clinical Sociology

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SOCIOLOGY AND CLINICAL PROCEDURE

The recent development of child guidance clinics and behavior research centers presents students of human nature and social relations with new opportunities and new problems. The history of science seems to demonstrate that whenever a body of theoretical knowledge becomes oriented and useful with reference to a concrete human problem a period of rapid development ensues. The evidence for such an accelerated development in the sciences that focus their attention on problems of personality is not wanting. This is particularly true of sociology, as is indicated by the growth of the literature and the research activities dealing with problems of personality and behavior, and by the increasing participation of sociologists in the work of child guidance clinics. So pronounced has this interest on the part of sociologists become that it may not be an exaggeration of the facts to speak of the genesis of a new division of sociology in the form of clinical sociology.

The notion of a "clinic" is derived from the Greek "reclining" and has come in medicine to be applied to bedside treatment. To some the term "clinical" may appear to be synonymous with "abnormal," since the need for treatment, in the older conception of medicine, seems to imply the existence of a disease or a pathology. Modern clinical medicine, however, seems to be characterized chiefly by the "case method" of study of the individual, rather than by its emphasis of the pathological. In the same sense clinical sociology is not necessarily—and in many respects not at all—synonymous with social

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pathology. It is, rather, a convenient label for those insights, methods of approach, and techniques which the science of sociology can contribute to the understanding and treatment of persons whose behavior or personality problems bring them under the care of clinics for study and treatment.

An analysis of clinical procedure indicates that it has three main characteristics:

1. The attention of the investigator is focused on a "case," i.e., on a person presenting concrete problems.
2. It is a co-operative enterprise and enlists the aid of a number of specialists.
3. Whatever may be the theoretical interests of the participants, clinical procedure has an immediate, therapeutic aim, and includes, therefore, not merely a study of the "case," but the formulation of a program of adjustment or treatment.

Until relatively recently, the sociologists have been so content with armchair speculation that they scarcely sought the opportunity nor felt the need for the fruitful first-hand contact with the human beings concerning whom they formulated their theories. It is therefore not surprising that those following a well-established tradition of scientific method which usually styles itself *pure science* should regard the occupation with cases on the part of the sociologist as distinctly unorthodox if not unscientific. On the other hand, there have always been a certain number of sociologists whose interests were so immediately practical that they identified sociology with social work. While clinics are, from the point of view of the community at least, primarily expected to produce practical results, the more successful and reputable ones have seen the necessity of combining the theoretical with the practical interests. The procedure that has developed seems generally to conform to the following type: *(a)* the case comes to the clinic with a statement of the problems presented as seen by the referring agency or person; *(b)* which is followed by the collection of data by the various investigators of the clinic; *(c)* there follows discussion among the specialists for the purpose of arriving at the facts; *(d)* which are then analyzed with a view of agreeing on a diagnosis; *(e)* to be followed by the formulation of a program of treatment; *(f)* whereupon attempts are made to carry out the program; *(g)* accompanied by periodic reexaminations and evaluations of the program adopted, and the diagnosis upon which it was based; *(h)* with the further effort of arriving at valid generalizations of principles and an improvement of techniques. Whether the theoretical scientific interest is actually in the mind of the various specialists that make up the clinic staff is not as important as the fact that out of the materials accumulated by these organizations may come facts of the greatest significance for the sciences that deal with human behavior.

To those who as a result of their academic traditions are somewhat shy about concerning themselves with practical problems, and who are inclined to stop short in their investigation at a point when it is likely to lead to practical consequences, it may be necessary to point out that sociology, like any other science, gains rather than loses by contact with real human problems. But this is not equivalent to saying that sociology is identical with social work, any more than physics is identical with engineering or physiology with medicine. All sciences are essentially theoretical, but they need not for that reason be divorced from problems of everyday life. On the contrary, the social sciences have no better way of testing their hypotheses and establishing their theories than by the patient accumulation and assimilation of the cases that actual human experience offers. If observing and working under something resembling laboratory conditions is a prerequisite of a science, as some seem to think, it may be remarked that a clinic comes as close to affording the setting for carefully controlled observation as the sociologist is likely to find. The interconnection between theory and practice has been stated by Cooley in terms that are worth quoting:

> The method of social improvement is likely to remain experimental, but sociology is one of the means by which the experimentation becomes more intelligent. . . . .
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> By observation and thought we work out generalizations which help us to understand where we are and what is going on. These are "principles of sociology." They are similar in nature to principles of economics, and aid our social insight just as these aid our insight into business or finance. They supply no ready-made solutions but give illumination and perspective. A good sociologist might have poor judgment in philanthropy or social legislation, just as a good political economist might have poor judgment in investing his money. Yet, other things being equal, the mind trained in the theory of its subject will surpass in practical wisdom one that is not.
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> At bottom any science is simply a more penetrating perception of facts, gained largely by selecting those that are more universal and devoting intensive study to them—as biologists are now studying the great fact of hereditary transmission. Insofar as we know these more general facts we are the better prepared to work understandingly in the actual complexities of life. Our study should enable us to discern underneath the apparent confusion of things the working of enduring principles of human nature and social process, simplifying the movement for us by revealing its

main currents, something as a general can follow the course of a battle better by the aid of a map upon which the chief operations are indicated and the distracting details left out. This will not assure our control of life, but should enable us to devise measures having a good chance of success. And insofar as they fail we should be in a position to see what is wrong and do better next time.

I think, then, that the supreme aim of social science is to perceive the drama of life more adequately than can be done by ordinary observation. If it be objected that this is the task of an artist—a Shakespeare, a Goethe, or a Balzac—rather than of a scientist, I may answer that an undertaking so vast requires the co-operation of various sorts of synthetic minds: artists, scientists, philosophers, and men of action. Or I may say that the constructive part of science is, in truth, a form of art.[1]

CLINICAL SOCIOLOGY AND SOCIAL PSYCHIATRY

As is usual in the development of new community activities, the technicians who are on the ground floor at the time of organization tend to assume the control and formulate the policies of the enterprise. In the case of child guidance clinics this has been both desirable and regrettable. It was fortunate that the physicians who were called to the direction of these clinics were for the most part specialists in mental disease, i.e., psychiatrists, but it was unfortunate that their training and experience in behavior and personality problems was relatively meager when compared with their training in medicine. It was fortunate that the direction of the child guidance clinics was from the beginning entrusted to scientifically trained men, but it was quite unfortunate that the psychiatrists who directed the clinics felt that with the inclusion of psychologists and social workers they had adequately taken account of the non-medical aspects of clinical work. The inclusion of social workers and psychologists in the staffs of the clinics seems to have been due to the close dependence of the clinics upon social agencies and the popularity of psychometric tests at the time of the organization of the earlier clinics, respectively.

The form of organization, which these clinics have taken, generally provides for a number of specialists:

> Such a clinic requires psychiatrists, physicians who deal with physical disease, psychologists, social workers, and a clerical staff. The director of such a clinic is a physician with special training in psychiatry, particularly that phase which deals with childhood problems. The psychiatrist is a physician trained in nervous and mental diseases, who views the problems presented from the standpoint of physical health. The psychologist, who is trained in determining mental abilities and disabilities, views them from the standpoint of the individual's abilities and disabilities and educational requirements. The social worker, who is trained in the application of social methods of investigation and treatment, considers them from the standpoint of the social factors involved.[2]

While one clinic differs from another in some respects, the general plan of organization conforms to this set-up. Where there is the problem of management there must, of course, be some authority, and where there are clients who come with their problems to an impersonal agency there must be some centralization of responsibility in a person who is professionally competent to assume it. The psychiatrist or the physician is the logical person, at least at the present stage of development, to be the director of such a clinic, although local circumstances and variations in set-up may, at times, justify a different practice. But there is no good reason for speaking of such a clinic as a "psychiatric clinic," for, if it is a clinic at all, it is a cooperative enterprise in which all the specialists concerned pool their knowledge, their insight, and techniques.

Most of the existing clinics have proceeded on the assumption that the psychiatrist, besides making and interpreting his own findings, also exercises the function of interpreting the findings of the psychologist and the social worker. But it cannot always be assumed that by virtue of his training and experience the psychiatrist is in a position to do full justice to these tasks. It is difficult to see why it should be tacitly assumed, as is so often done, that physicians have more psychological knowledge and sociological knowlege than psychologists and sociologists have medical knowledge. There is no reason for supposing that the one is less technical than the other and that the one can be acquired with less training than the other. If a psychiatrist happens to show a penetrating understanding of a critical family situation, or if he happens to be able to isolate the factors that lie back of the break-down of community control in a given case, it is no more due to his training as a psychiatrist than if a sociologist happened to be correct in his guess that the behavior of a child was in part due to a fractured skull or to hyperthyroidism. In both instances we have nothing more than the opinions of laymen. Unless the psychiatrist, besides his training in medicine, neurology, and psychiatry—which, it seems is

enough to keep one man occupied for a good share of his lifetime—can also equip himself as a specialist in pschology and sociology, there is no reason to expect from him more than a layman's judgment in these fields.

It is not strange to find that most child guidance clinics have not thought of including a sociologist in their staff, when one considers that until recently there were only a few professional sociologists who interested themselves in the concrete and very practical problems of human behavior presented by child guidance clinics. Meanwhile the social workers have become not merely the interpreters of the social sciences but have also translated the theoretical knowledge of these sciences into practical working techniques. Partly as a result of this they have become the backbone of the clinic staffs. It is largely through the influence of the social worker that the social factors in behavior problems have been called to the attention of the psychiatrist. The social workers in many instances have assimilated the psychiatric viewpoint, with the apparent result that a new type of psychiatry seems to be emerging, distinguished from the older by its emphasis on the situational factors in personality development and behavior problems.[3] In one modern child guidance clinic the interest in physical treatment has been almost completely displaced by "social-psychiatric" treatment. The director of this clinic says:

> In general, treatment proceeds (as is common in child guidance clinics) through the joint efforts of psychiatrist and social worker and frequently the psychologist. The Institute does practically nothing in the way of physical treatment, referring cases needing such to the family physician (or family specialist) or to the clinics to which the patients would ordinarily go. So far as the major efforts are concerned, the most important phases of the treatment are contributed by the psychiatric social worker in her attempt to remold attitudes in the home, the school and elsewhere, and by the psychiatrist in his work with the individual patient, or, in many instances, with parents, where the psycho-therapeutic problem is at a level beyond that to which the social worker is prepared to go. *There is here the application of psychiatric principles and techniques to the influencing of the social situation; and the shifting of various elements in the social setting to influence the psychiatric situation.*
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> This emphasis on social-psychiatric treatment is the keynote of practically all mental hygiene effort at the present time. Its evolution has brought such work to the point where diagnosis for diagnosis' sake is not regarded as particularly valuable. Instead, *diagnostic formulation* of all the issues in the situation is regarded

> as of value *only* as a means for the development of the treatment process. To the social worker, teacher, or parent the application of a diagnostic label to a child who is in difficulty may have some value, but increasingly these groups are demanding more than labels. What is wanted is some understanding of the situation (including all the individuals important in it) and how it evolved, in terms of what may be done about it. This emphasis on treatment or, as it is commonly called, adjustment, in schools, social agencies, and the community at large, has necessarily led to a reformulation of diagnostic concepts. In practice, this has meant the interpretation and formulation of all the elements of the entire situation, instead of the application of a single diagnostic formula. Some of the leading psychiatrists of the country, notably Adolf Meyer, have long insisted that this is the necessary thing in psychiatric work namely to see all the elements in the total picture which the patient shows, and particularly those upon which a reintegration of personality or social relationships may be built. This evolution in psychiatric practice accordingly is not so novel as it might seem: instead it is a logical development in the application of psychiatry to the problems of behavior and personality.[4]

That the discovery of social relations on the part of psychiatrists should have been so long delayed is not surprising in view of the academic and clinical training which medical men have been accustomed to receive. The opinion has sometimes been expressed by social workers that, after collecting the social histories on patients that are to be examined by psychiatrists, they often received nothing more from the psychiatrists in return than excerpts from their own social histories to which the psychiatrist added a diagnostic label, which, except in cases of institutionalization, was of little practical value in treatment. While this is undoubtedly an exaggeration, it is a point which demands consideration. It appears that the division of labor between psychiatrist and social worker has been based upon a traditional and authoritative arrangement rather than upon actual differences in technique, although there can be no question about the fundamentally different backgrounds in the training for the two professions. It is difficult, for instance, for social workers who have an acquaintance with sociology and social psychology to understand why the treatment of the patient has to be administered by the psychiatrist while the treatment of the members of the patient's family and the members of his social groups can safely be intrusted to the social worker. The question which they sometimes raised was: Why is the process of changing the patient's attitude psychiatric treatment or "psychotherapy," while changing the attitude of the patient's wife or mother is social treatment? The fact that psychotherapy is generally carried on behind the closed doors of the psychiatrist's office and is

scarcely ever described in objective terms may account for the confused opinions about it and the skepticism with which it has been received in some quarters. In substituting the medical for the moral point of view in matters of human behavior psychotherapy undoubtedly constitutes a great advance upon previous approaches, but it is regrettable that one can find no clear description of this approach in the literature. In most of the textbooks on psychiatry one searches in vain for as objective and concrete a description of the psychiatrist's technique as the psychoanalysts have given of their method of procedure. Until this technique is more than the secret of the individual practitioner it is hazardous to attempt to pass any scientific judgment upon it.

THE CULTURAL APPROACH

A number of clinics have developed in various parts of the United States in which, in addition to the usual psychiatrists, psychologists, and social workers, the staff includes sociologists as well. Some of these clinics in order to differentiate themselves from the so-called psychiatric clinics have labeled themselves "sociological clinics." But just as the psychiatrists are retreating from the extreme and unwarranted claims of some of the members of their profession, so the sociologists will probably give up the anachronism of a sociological clinic, for the vary nature of a science renders it incapable of solving any problem by itself. While one may legitimately speak of the psychiatric approach or the sociological approach to behavior problems it is impossible to conceive of either a psychiatrist or sociologist constituting a clinic by himself. The factual and practical knowledge that the representatives of the various scientific disciplines may have to contribute toward the understanding and treatment of a given problem or case is much less clearly differentiated one from the other than the theoretical dividing lines between the respective sciences and techniques seem to indicate. In actual practice the function played by each depends perhaps more upon the personal knowledge and background of the scientist and technician than upon the theoretical claims of the science he represents. This does not obviate the necessity, however, of formulating, as clearly as it can be done, the distinctive points of view and techniques of each.

An attempt to state the sociological approach to those behavior problems that are generally dealt with by child guidance clinics has recently been made by Thomas[5] on the basis of what is taking place in practice rather than what is desirable in theory and defensible as a program. It is difficult to gather from this statement the precise characteristics which differentiate the sociological

from other approaches to personality and behavior problems. The emphasis upon "conditioning" in the formulation of the sociological approach, as represented by Thomas, would be regarded by many as distinctive of the physiological and the psychological point of view. In fact, the sociologist and social psychologist would be inclined to be critical of the notion of conditioning as it has been taken over by the psychologists from experiments on animal behavior to the realm of human conduct on the ground that physical stimulations must always be seen in the light of the meaning which they have for a particular person, and are significant for the explanation of conduct only when seen in terms of the interpretation which the individual puts upon them. Similarly, the claim that the "total situation approach" is distinctly a contribution of the sociologists would be difficult to defend in view of the fact that the social psychiatrists from Adolf Meyer and William Healy to the most recent representatives of this point of view have been emphasizing the need of viewing the child from the standpoint of the total situation. Whether these men have profited from the sociological literature in arriving at this point of view is not a matter of importance unless one is interested in merely establishing priority of claims between the various sciences. Perhaps the greatest contribution of the sociologists thus far has been the attempt to correct the shortcomings and especially the particularistic fallacies of those who have traditionally been concerned with these problems.

The positive contributions of the sociologist, the results of which in practical terms have thus far been only partially realized, seem to consist in what may broadly be characterized as the cultural approach to behavior problems. If the sociological approach has any significance then the notion that behavior, whatever else it may be from other points of view, is a cultural product, is a crucial starting-point. The sociological approach to behavior rests upon the recognition that a person is an individual with status,[6] and that personality is "the sum and organization of those traits which determine the role of the individual in the group."[7] It is not merely a verbal difference but a fundamental question of orientation, as Burgess has shown,[8] whether the child is studied as an individual or whether he is studied as a person. The cultural approach to personality does not rule out as insignificant the biological, the psychological, and the psychiatric approach, but illuminates phases of behavior which can not be adequately understood in terms of the latter. Furthermore, if the behavior of the child is seen as a constellation of a number of roles, each oriented with reference to a social group in which he has a place, his organic and psychological traits are thereby not excluded as unimportant, but become capable of interpretation with reference to their social significance. For example, a boy, whose parents have had the bad judgment to name him Percival or Oswald, may, in a given cultural milieu of his associates, be suffering from as significant a stigma as if he had one leg or a harelip. It is not

desirable that the sociologist should displace the physician, the psychiatrist, the psychologist, or the social worker, but he should bring to them the insights which his approach furnishes not merely in order to modify their viewpoint but to understand the child's behavior more completely as a social phenomenon.

A fact that is often overlooked is that the behavior problems of children are problems only because the child lives in a family, goes to a school, or is a member of a community which regards this behavior as a problem. His behavior is recognized as a problem only because it takes place in a culture which has given to the action of the individuals the imprint of its definitions of conduct. Being lazy is not a great problem in a child if that child is a member of a family that expects no work of it; being "finicky" about food is seldom a problem in children that come from families in which food is scarce. Even stealing is not a problem in a child that lives in a family of thieves, although the community may regard it as such. One might even go as far as to say, as practical experience seems to demonstrate, that being unintelligent is not an irreparable disaster in a child that is born into a family of wealth. Behavior problems turn out to be those forms of conduct which the person himself or others with whom he comes in contact regard as problems.[9] There are, of course, many parents and psychiatrists who recognize this fact, but there are many more who do not. Similarly, there are still some who speak of reality as if it were a definite something that is the same for all classes and places, and who, therefore, fail to realize that a person is not necessarily pathological because his attitudes toward others and his conceptions of reality differ materially from those of others. In such instances the sociologist is in a position to point out that a child's world is real if he can get the people who are significant in his life to accept it as real.

The sociologist, insofar as he has a point of view and method of approach to problems of personality and behavior, proceeds on the hypothesis that human beings everywhere live in social groups and that the conduct of the individuals, however it may differ from others, is always expressive of the culture of the group. But a child, for instance, in our type of civilization is seldom just a member of one group, except during the earliest period of life, but of many intersecting and conflicting groups and may at times show behavior traits which are at variance with the standards of the group of which we are accustomed to regard him as a member. These differences in group standards may be gross or they may be very subtle. A child's loyalty to the dictates of his gang may account for his disobedience of the rules of family life. Or the subtle influences of the personality of a teacher may change the honesty curve of children passing from one school room to another.[10] Even the "intelligence" of children as measured by tests may change as the child is trans-

ferred from one foster home to another.[11] What is sometimes regarded as the one element in the life of the individual capable of exact and objective description, namely, the so-called environment, can be shown to be different for every person, so that different children living in the same family do not have the "same environment."[12] A recent study of the Molokan colony in Los Angeles, a sectarian Russian immigrant group,[13] offers a striking demonstration of the value of the cultural approach to delinquency. There were age groups in this community in which the delinquency rate was almost negligible and others in which it was astoundingly high. The data of the psychologist, the psychiatrist, and the social worker apparently did not furnish any plausible explanations for the delinquent careers that occurred in the group and failed to reveal any significant differences between the delinquents and non-delinquents. But when the cultural history of the community was analyzed the explanation became apparent. These and similar insights are indicative of the significance of the sociological approach to behavior problems.

However firmly convinced the sociologist may be that he has a contribution of value to make to clinical procedure, it is often difficult to convince others, especially orthodox psychiatrists, that this is so. That the sociologist has, perhaps, an understanding about the family, boys' gangs, community life, social institutions, and other phases of group life, is quite generally admitted. What some psychiatrists are not so ready to grant is that the sociologist may have a contribution to make to the study of personality and individual behavior problems which is not already represented by other members of the clinic staff.

For example, in the organization of a child guidance clinic, recently, the psychiatrist representing a foundation interested in the project insisted that if a sociologist were included in the staff his function would have to be restricted to the "investigation of the social groups of the patient," while the social worker investigated the "environment." That such a restriction, which prevents the social worker and sociologist from having contact with the patient, if literally followed, would prevent effective work in the clinic is quite obvious. At least, insofar as the social worker is concerned, the established practice in clinics is to the contrary.

The question has been raised, what additional material the psychiatrist would gather; outside data bearing on the physical, the neurological, and the emotional conflict aspects of the patient, if he did not have the social worker's social history before him. The experiment now being tried in one clinic in New York City of not giving the psychiatrist any social history when he examines the patient will be worth watching for its outcome. It is, of course, necessary in any clinic to conserve the energy, the patience, and the good will of the patient

by preventing unnecessary duplication of questioning, but there is no good reason for assuming that sociologists and social workers will be less successful as interviewers than are psychiatrists, or that the findings of the sociologists and social workers will be less valuable and substantial. If the sociologist is to work successfully in a clinic it is essential that he have access to the patient as freely as everyone else concerned with the problem, for to investigate groups in the abstract without contact with the persons that compose them is not likely to be very useful in clinical procedure.

THE SCOPE OF CLINICAL SOCIOLOGY

The scope of the sociologists' activities remains to be more precisely defined as their experiences in these clinics accumulate. While it is not practicable to set down a priori the functions that the sociologist is to serve, at least three avenues of possible usefulness in a child guidance clinic suggest themselves:

1. He might devote himself exclusively to research. The materials which these clinics usually collect offer opportunity for this.

2. He might act as consultant to the other members of the staff and might be of use in training social workers and psychiatrists in those phases of their work of which the sociologist has special knowledge. This might serve to introduce the cultural approach to behavior problems to other specialists.

3. He might directly participate in the study of cases and in their treatment. This would involve interviewing and other contact with patients, study of their social world, the collection and analysis of life-histories, contacts with the community, the school and social agencies, participation in staff conferences and the participation in programs of adjustment. Out of the experiences with sociologists in such co-operative work will undoubtedly grow a division of labor between the members of the clinic staff through which duplication of effort will be reduced to a minimum. In the existing clinics in which sociologists participate all three varieties of functions are represented. In some clinics the sociologists, in addition, serve as directors, which, however, does not materially affect their technical function.

The question might be raised whether the sociologist has anything to contribute to clinical work which is not already adequately supplied by the social worker whose training, it may be supposed, is at least partly sociological. The answer will, of course, depend upon the resourcefulness, the imagination, the insight, the interests, and the specific training of the social workers and the

sociologists in question. The cultural approach, represented by the sociologist, has thus far not been in evidence, except incidentally and fragmentarily, in clinics in which sociologists have not taken part. The heavy burdens and the wide range of activities of the social workers at present make it difficult to devote the necessary attention to the specialized and technical phases of personality and behavior problems which the sociologist is in a position to deal with. In addition to his present training and training in psychiatry the social worker in a child guidance clinic needs to be trained in clinical sociology. Nothing indicates more clearly that the sociological approach has been largely neglected by psychiatrists and psychiatric social workers in the past than the outlines for history-taking that are still in use in most clinics.[14] These outlines are oriented largely with reference to the psychiatric and psychological factors and the physical resources for the treatment of the patient. In most of them, for instance, there is a great deal of attention paid to biological inheritance, and almost none to family traditions; much to the physical surroundings, and little to the social world; a great deal to the delinquencies and failures to adjust to school, to the home, to companions, and occupation, and relatively little to the interplay of attitudes between the child and those with whom he comes in contact and the cultural conflicts under which he labors. The habits of the child are generally recorded minutely, but the group customs of which they generally are a reflection and the milieu out of which they grow are often ignored. Objective descriptions of the fears, grudges, loyalties, aversions, and attachments are recorded as are the persons and objects toward which they are directed, while the private and personal meanings which they have for the child are often overlooked. If the sociologist can obtain some insight into the motives and attitudes of the child, his intimacy and distance to others, the personal meanings of the factors in the situation in which he finds himself, and if he can more fully understand the behavior of the child in terms of the culture of the groups of which he is a member, he is dealing with elements which, although they are not physical, are nevertheless real and significant. If, in addition, the technique of community analysis, in which the sociologists have made a distinct contribution, can be extended to similar analyses of family and group life, their services will be indispensable.[15]

The sociological approach to behavior problems will remain mainly theoretical and academic unless it also evidences an interest in controlling and reconstructing the behavior of the child. It is of more than theoretical significance, consequently, what we conceive the nature of personality to be. Our conception must not merely conform to the facts, but in order to be fruitful clinically it must also furnish clues for treatment. The possibility of the sociological technique, which is in the course of development through the practice of the increasing number of clinical sociologists, can here be only tentatively outlined.

"What distinguishes the action of men from animals may best be expressed in the word 'conduct.' "[16] According to Park, conduct is self-conscious and personal, it is conventional behavior and consists of action that is oriented with reference to a goal which is not immediately present. This accounts for the fact that we usually confine our moral and legal judgments to the conduct of human beings. It is this element which raises the actions of human beings to the level where they are regarded as "behavior problems." The life-history document, especially the autobiography, acquires for this reason a special significance, not only in the understanding of the conduct of the individual, but also in the control of this conduct and the reconstruction of his personality. The telling of his life story or the writing of his autobiography on the part of the delinquent may be one of the most effective devices in a therapeutic program.[17]

One of the major therapeutic tasks in which the sociologist is likely to have a primary interest is the modification and manipulation of the child's social world. If changes in behavior can be brought about by making changes in the school, home, and community life, as is amply demonstrated by experience, then here is a phase of therapy to which the sociologist may properly devote himself. William I. Thomas, some years ago, suggested the possibility of "beneficent framing" as a method of social therapy. By this he meant the deliberate manipulation of the child's social world in order to make it more responsive to his wishes. The substitution of socially approved for socially disapproved values as satisfaction for the wishes of the individual opens a field of broad possibility to the sociologist in which the social worker is equipped to co-operate effectually. This "beneficent framing" involves frequently the modification of the attitudes and the behavior of members of the child's social world. From the standpoint of the child two major therapeutic techniques present themselves, viz., the modification of the child's attitudes toward his social world and the significant people in it, and the modification of his conception of himself. That these techniques are all fundamentally interrelated needs no argument. In the actual working out of such programs the sociologist will, no doubt, have much to learn from the social workers, who have been gaining practical experience in these matters for many years, without, however, being fully aware of all that the sociological approach to behavior problems implies.

The function of the sociologist in child guidance clinics is not to displace the psychiatrist, the psychologist, and the social worker but to enrich the resources of these clinics through the introduction of a point of view and a method which have hitherto been largely neglected. One danger of the rapid development of the field of clinical sociology seems to be that the claims which the sociologist makes for himself are apt to be exaggerated and he is likely to begin to look upon himself as a member of a cult. For this reason it is

necessary to insist that the sociologist had better be rather modest in his claims and bear in mind that by himself alone he is incapable of dealing with clinical problems effectually. It is also necessary for the sociologist always to safeguard himself against the possible charge of quackery by taking the fullest account of the medical and psychological factors in the child's behavior and not to undertake the treatment of behavior problems without fully assuring himself that the medical and psychological factors are passed upon by specialists in these fields. The problem of greatest significance at present seems to be to keep the clinics from becoming the battleground of various groups of specialists each with a vested interest, and to keep the point of view and method of procedure flexible and experimental rather than caked with ritual and dogma. In this way we shall be promoting not merely our own science but shall aid in the building up of communities of scholars each of whom is conscious of his own limitations and his dependence upon others for the solution of a common problem.

NOTES

1. Charles Horton Cooley, *Social Process*, pp. 402-4.
2. Lawson G. Lowrey, M.D., *A Child Guidance Clinic, Its Purposes and Methods of Service.* New York: National Committee for Mental Hygiene, p. 4, 1924.
3. The organization of the "Committee on Relations with the Social Sciences" by the American Psychiatric Association, and the emphasis on the social factors in the programs of the American Orthopsychiatric Association are indicative of this change (see *Program of Seventh Annual Meeting*, New York, February 21-22, 1930).
4. Lawson, G. Lowrey, Director, Institute for Child Guidance, New York, *Report for the Year Ending June 30, 1928*, pp. 23-25.
5. William I. Thomas and Dorothy Thomas, *The Child in America* (New York: 1929), chaps. xii and xiii.
6. "The person is an individual who has status. We come into the world as individuals. We acquire status, and become persons. Status means position in society. The individual inevitably has some status in every social group of which he is a member. In a given group the status of every member is determined by his relation to every other member of that group. Every smaller group, likewise, has a status in some larger group of which it is a part and this is determined by its relation to all the other members of the larger group. The individual's self consciousness — his conception of his role in society, his 'self,' in short — while not identical with his personality is an essential element in it. The individual's conception of himself, however, is based on his status in the social group or groups of which he is a member. The individual whose conception of himself does not conform to his status is an isolated individual. The completely isolated individual, whose conception of himself is in no sense an adequate reflection of his status, is probably insane. It follows from what is said that an individual may have many 'selves' according to the group to which he belongs and the extent to which each of these groups is isolated from the others. It is true, also, that the individual is influenced in differing degrees and in a specific manner, by the different types of groups of which he is a member.

This indicates the manner in which the personality of the individual may be studied sociologically" (Robert E. Park and Ernest W. Burgess, *Introduction to the Science of Sociology*, p. 55).

7. Ibid, p. 70.
8. E.W. Burgess, "The Study of the Delinquent as a Person," *American Journal of Sociology*, XXVII (May, 1972), 657-80.
9. For differences in evaluation of behavior problems by teachers and mental hygienists see E.K. Wickman, *Children's Behavior and Teachers' Attitudes* (New York, 1928), p. 188.
10. See M.A. May and H. Hartshorne, *Character Education Inquiry, Studies in Deceit*, New York, 1928. For a discussion of this question in which psychiatrists and social scientists participated see *Proceedings of the First Colloquium on Personality Investigation*, American Psychiatric Association, New York, December 1-2, 1928, especially pp. 49-54.
11. Frank N. Freeman and Others, "The Influence of Environment on the Intelligence, School Achievement, and Conduct of Foster Children," *Twenty-seventh Year Book of the National Society for the Study of Education*, Bloomington, Illinois, 1928.
12. Blanche C. Weill, *The Behavior of Young Children in the Same Family*, "Harvard Studies in Education," No. 10.
13. Pauline V. Young, *The Holy Jumpers of Russian Town*, Manuscript, chap. x, p. 19, and "Urbanization as a Factor in Juvenile Delinquency," *Proceedings of the American Sociological Society, XXIV (1930), 162-66.*
14. See Myrtle Storm Mink and Herman M. Adler, M.D., *"Suggested Outline for History Taking in Cases of Behavior Disorders in Children,"* reprint from March, 1926, *Welfare Magazine*, and Bibliography of other outlines at end of article.
15. For a summary of the significance of the community analyses thus far made by sociologists see Ernest W. Burgess, "The Cultural Approach to Behavior," *Mental Hygiene*, XIV (April, 1930), 307-25.
16. Robert E. Park and Ernest W. Burgess, *Introduction to the Science of Sociology*, p. 191.
17. See Clifford R. Shaw, *The Jack-Roller*, Chicago, 1930. This technique is in many respects similar to that used by the psychoanalysts, but is in striking contrast to "moralizing."