Knowledge is the beginning of practice; doing is the completion of knowing. Men of the present, however, make knowledge and action two different things and go not forth to practice, because they hold that one must first have knowledge before one is able to practice. Each one says, “I proceed to investigate and discuss knowledge; I wait until knowledge is perfect and then go forth to practice it.” Those who to the very end of life fail to practice also fail to understand. This is not a small error, nor one that came in a day. By saying that knowledge and practice are a unit, I am herewith offering a remedy for the disease.

Wang-Yang-Ming, 1472-1529
# CLINICAL SOCIOLOGY REVIEW
## Volume 2, 1984

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EDITOR'S PREFACE

The Clinical Sociology Association publishes *Clinical Sociology Review* annually.* The journal brings to its readers the most recent contributions in the field as well as classical papers of historical significance. The *Review* is addressed to a wide audience of practitioners, policy makers, teachers, and students committed to the application of sociological insights to effect positive social change.

**Symposium.** This issue features two classic pieces by Saul Alinsky on community organizing and clinical criminology. Commentaries by Billson, Glass, and Freedman help to put Alinsky's work into perspective.

**Current Contributions.** The articles in this section range across a broad spectrum of clinical sociological practice, beginning with a historical piece by Alfred McClung Lee, one of the clinical sociology movement's founders, and a theoretical framework for sociological practice by Roger A. Straus. Gary Voelkl and Kenneth Colburn explore the connections between the strategic communication approach to family therapy and sociologically based clinical practice. At another level, Douglas B. Gutknecht elaborates on the sociological aspects of organizational development and analysis. David J. Kallen, a medical sociologist, explicates the uses of sociology in designing an adolescent treatment unit in a hospital. Bernie Jones offers several principles that guide practice with design professionals in planning and environmental settings. Kevin Preister and James A. Kent discuss the relevance of sociological theory and concepts to large-scale intervention in social impact assessment and management.

**Professional Notes.** The significance of organizational context and support for sociologically based interventions is explored by Katherine Goldman, who consults with social agencies and industries in the stress management area.

**Teaching Notes.** Jean H. Thoresen contributes to our understanding of teaching as a process that can be harnessed for clarification of student values. Some principles governing evaluation of teaching effectiveness are suggested by Thomas J. Rice, who argues that such evaluation must be theoretically grounded and practical.

**Book Reviews.** In an extensive Review Essay, Betty Reid Mandell critically evaluates a recent collection of important works in the field of ethnicity and family therapy edited by Monica McGoldrick et al. John Glass reviews Harry Cohen's *Connections*, a significant contribution to the field of clinical sociology that throws into relief explicit connections between various sociological perspectives and practice. Finally, Leo Miller's review of Marie A. Matthews's *The Social Work Mystique* compares social work and clinical sociology, highlighting both similarities and differences between them in theoretical perspective and practice orientation.

Janet Mancini Billson

*Volume 2 is the 1983–1984 issue.*
About The Authors

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JAMES A. KENT organized the Foundation for Urban and Neighborhood Development (FUND) in 1967 as a nonprofit corporation to address the need to develop practical approaches to preventing social disharmony in society. In 1982 he started SRM (a profit company) to continue the consulting work of FUND. His approach to resolving social issues led to the early development of a training approach designed to develop people's capabilities to predict and thereby control their environment. As Executive Director of FUND, he has worked with professional groups, government agencies, Native Americans, rural communities, and urban neighborhoods to design social impact management systems that maintain local control while accommodating development and change in social and economic conditions. A sociologist and lawyer, Kent
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KEVIN PREISTER, since joining Foundation for Urban Neighborhood Development in 1979, has worked on numerous projects related to social impact assessment, retraining, and consultation. He was field director for the social impact assessments for the Adam's Rib Recreational area and the Homestake II Water Diversion Project in western Colorado. Preister has been active in FUND's training programs for improving the social understanding and responsiveness of government and corporate clients, including the oil and gas industries, the Philippine Ministry of Forestry, and public utility companies. He has worked on a Denver cable franchise effort to develop a grant program for community ownership and investment potential offered through low-cost company shares.

In January 1983, Preister opened a northwest divisional office for FUND in Ashland, Oregon. He is offering services and training programs related to
water development, chemical waste, energy development, and alternative energy development. He earned his B.S. in psychology at Colorado State University and an M.S. in anthropology at Catholic University of America.

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ACKNOWLEDGMENTS

The Clinical Sociology Association gratefully acknowledges the institutional support of Rhode Island College in making this issue possible. Special appreciation is due to the Dean of Arts and Sciences, David Green; to the Department of Sociology; and to the professional staffs of Adams Library and Office Services. We are also appreciative of the professional cooperation and editorial expertise of the publisher of General Hall, Ravi Mehra, and his editorial staff.
Saul Alinsky: The Contributions of a Pioneer Clinical Sociologist

Janet Mancini Billson

Saul D. Alinsky, sociologist in the Chicago School tradition, self-styled radical, visionary of a better society. His work has remained on the periphery of sociology, attended to more often by social workers and political activists than by academic sociologists. Yet now that we look back on his work through the lens of the current reemergence of the clinical sociology movement, it is clear that Alinsky is an early example of an interventionist steeped in the sociological and anthropological traditions.

Two pieces reprinted here, a 1934 article on clinical criminology and one on community organizing dated 1941, reveal a sociological practitioner at work. In the first article, Alinsky describes through a series of case analyses his work with individual juvenile delinquents in the Chicago inner city. Although he claims that his intent was not to change their behavior, he elicited more realistic case histories of the boys through his methodology than did the “formal” case interviews typically conducted by juvenile workers of that time. This in turn should have facilitated more effective intervention on the part of the helping staff. Alinsky offers no solutions to the delinquent behaviors presented by the youths, nor prescriptive strategies for changing them. He engages, rather, in a fascinating interplay between participant observation methods that yield him intimate knowledge of a juvenile’s community and interviewing techniques that bring that knowledge to bear on a boy’s presentation of self.

It must be remembered that Alinsky studied under Clifford R. Shaw, the University of Chicago sociologist who wrote the classic case study of a delinquent, The Jack Roller (1966), and who conducted the famous “area projects” attempting to uncover the sources of delinquency in the social turmoil of
Chicago in the 1930s. The social context of individual behavior was paramount in the thinking of the time. Alinsky worked within the broad framework referred to as "the cultural approach to behavior problems." As Wirth (1931:49–66) stated in his article on clinical sociology, "The sociological approach to behavior rests upon the recognition that a person is an individual with status, and that personality is 'the sum and organization of those traits which determine the role of the individual in the group.'" Alinsky is a clinical sociologist in the sense that he utilized a diagnostic case approach in which he sought to fathom the problems of the individual's "reference" group.

Alinsky was a social diagnostician par excellence who paved the way for others to work for specific behavioral changes. It is critical that he was part of a clinical team, similar to the multidisciplinary teams working in child guidance clinics around the country in the era (Wirth 1931). As Wirth argued, the sociologist's role in such settings as clinics, detention centers, or settlement houses might be limited to background research on the community context; on the other hand, it might be extended to consultation with other staff members or to training them in the "cultural" approach. Finally — and we would see this now as a more complex role — Wirth felt that the clinical sociologist "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 programs of adjustment."

Alinsky obviously involved himself in this fuller role, utilizing his own community-based adaptation of the "life history" method developed by Shaw. By engaging the juvenile in a relatively open and more complete accounting of his life history, it can be argued that Alinsky stepped out of the research role and into the realm of therapeutic interaction. Wirth wrote, "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." A fundamental principle behind almost all therapies is that open communication, ventilation, and catharsis are essential for movement toward insight, then change.

Alinsky understood, without benefit of psychoanalytic training, the importance of establishing rapport with his young delinquents: "In the major part of the interviews in which a highly unusual degree of rapport is secured, a more accurate and valid portrayal of the attitudes, objectives, conceptions of the self and causative factors in delinquency is obtained" (Alinsky 1934). In part this rapport is established through the use of the boy's vernacular, which Alinsky would already have mastered by virtue of his participant observation research in the community. The model Alinsky chose to use for probing, elaborating, and expanding communication was sociological.

Similarly, in the piece on community organizing we find Alinsky's grip on the cultural context of community in explaining (and changing) individual
behavior. His analysis of the interplay between Catholicism and labor union activities in the Back of the Yards neighborhood of Chicago is prototypical. He emphasizes once more the proper conception of the individual problem as merely an example of a larger social problem experienced by others in the same social stratum. C. Wright Mills's later distinction between "personal troubles" and "social issues" (1959:8,9) is similar to Alinsky's perspective. Alinsky hearkens back to his Chicago School training as he attempts to define the problems faced by individuals in a poor inner-city area as reflections of social structure defects that go beyond the person and even beyond that specific community: "Their problems are the same, the causes of their problems are the same, and the organic character of these industrial communities is very similar" (1941).

The writing is Marxist in orientation, with a strong emphasis on the centrality of economics and the "major destructive forces which pervade our entire social order" (1941). Alinsky is referring to socioeconomic inequalities and assuming that various racial, ethnic, and religious groups hurt themselves by nursing prejudices and perpetuating isolation and competition. He was convinced that only when people realize that their differences are outweighed by their commonly shared problems will they achieve true community (and the solution to those problems). On a larger scale, this is Marx's distinction between a "class for itself" and a "class in itself." The latter does not become the former until "false consciousness" is eliminated.

Although Alinsky does not elucidate these theoretical linkages or specify the roots of his conceptualizations, sociological threads are woven throughout the fabric of his approach to social change. To Alinsky, power, community, and organization are inextricably connected in theory and inseparable in practice. He apparently was influenced by Wirth's analysis of the negative impacts of urbanism as a way of life (1938) and saw the formation of umbrella community organizations as an antidote to the alienation, apathy, and isolation predicted by many urban theorists, including Tönnies, Maine, Durkheim, and Redfield.

In viewing Alinsky's work retrospectively, we must acknowledge several ethical and methodological problems that are of concern to contemporary clinical sociologists. For example, if the study discussed in "A Sociological Technique in Clinical Criminology" were conducted today, guarantees of confidentiality would be made to the participants. The use of research data gathered from specific individuals to determine their fate in a classification system might be considered unethical. It appears that, since Alinsky knew the general life style of the "delinquent," he did not mind lying to obtain additional information to confirm suspected "anti social" behaviors that a prisoner would not otherwise confess. It is ironic that in "Clinical Criminology" Alinsky—who later became so concerned with the influence of society on the individual—
might be viewed as using his knowledge of society to reinforce the power of the state over the individual.

From "Community Analysis and Organization" it is not clear whether Alinsky's success stemmed from his theoretical approach, his charisma, or the development of techniques that worked at a specific point in history (i.e., were appropriate for Chicago in the late 1940s and 1950s). Freedman's experience suggests that Alinsky's success may have been charismatic or a function of the times. In 1941 the country was emerging from the Great Depression as it prepared for entry into the Second World War; as the economy expanded, so did opportunities for social accomplishments. Alinsky reports what was accomplished, but tells us little about how it was brought about. While the lives of many residents of the area were probably improved by the creation and existence of the Back of the Yards Community Organization, it is not clear what made the organization effective.

Dark edges that seem apparent now may be evident because in the four decades since the articles were written, our ideas about ethics, procedures, and the relationship between the individual and society have changed. It is thus unfair to view Alinsky's work solely from the modern perspective; for his time and place, he was a radical change agent, dedicated to righting the then-perceived wrongs of society. The times were less sensitive to the issues of ethics and protection of individual liberty from the conformity demands of institutions. That does not mean, however, that we should be insensitive to those issues today in reflecting on Alinsky's work, or on our own.

Retrospectives by John Glass and Jonathan Freedman, two clinical sociologists who had personal contact with Alinsky, follow the selections from Alinsky's writing. As Freedman and Glass suggest, Alinsky was both dynamic and fallible. The lessons he taught were not always well received; his values were not always those that we of a more sophisticated era might applaud. Still, Saul Alinsky emerges from the Chicago School tradition as a humanistic change agent whose ideas deserve our careful attention.

NOTES

1. I am indebted to David J. Kallen of Michigan State University for pointing out these questions regarding Alinsky's approaches to social change.

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A Sociological Technique in Clinical Criminology

Saul D. Alinsky

For the past year the writer has held the position of staff sociologist and member of the classification board at the Illinois State Penitentiary — Joliet. Prior research work had resulted in a fund of detailed and intimate knowledge of the background of individual delinquents and social factors in crime. This fund of first-hand research data was utilized for classification purposes. The material would roughly fall into five divisions:

A. The general neighborhood situation.
   1. This would embody a detailed picture of the community both physically and socially.

B. Criminal techniques.
   1. An intimate knowledge of the techniques employed and the degree of criminality indicated by the latter.

C. The typical sequence of delinquent experiences in the criminal career.

D. Acquaintance with many delinquents.

E. A first-hand knowledge of the group nature of delinquency, development of criminal attitudes, and social factors operating in delinquency and crime.

It should be clearly understood at this point that the writer is only speaking of the delinquent or criminal coming from the very deteriorated areas of Chicago and regarded as the gang boy. It is these areas that research has demonstrated have consistently high rates of delinquencies.

All of the writer's past research experience has been based upon the premise that in order to gain insight, one should be on the inside of the prob-

lem as much as possible. Prior to the writer's affiliation with the classification board he had been engaged in a two year research study of a delinquent gang. This delinquent group resided on the near west side of Chicago in a deteriorated immigrant area which is well known for its consistently high rate of delinquency. This gang ranged in number from fifteen to, at intervals, as many as forty.

During this period the research relationship of the writer to this gang might aptly be described as that of a non-participating member. A degree of informality and confidence existed which was uncommon. At no time was any attempt ever made to change behavior, as research was regarded as the only function of this project. Continual daily association, observation and study followed for a period of more than two years. During this time fifteen members of the gang wrote their life histories in detail. It is apparent that under such constant and prolonged study these gang boys were observed in the most varied situations.

Material was secured pertaining to the group nature of delinquency and the development of delinquent attitudes and objectives. The delinquent vocabulary was learned and studied. This was done because language, while serving its immediate end of communication, is very revealing as to the attitudes, values, and cultural configurations of the group. Studies of criminal traditions and behavior patterns were made of the area. A detailed picture was secured of the local rendezvous, receivers of stolen property, the local political organization, community personalities, garages, theatres, restaurants and similar physical and social aspects of the community. First-hand knowledge was obtained regarding the well-known criminal personalities of the area. Family situations were studied as related to the delinquent activities of this gang. Various criminalistic techniques were analyzed as indices in the development of delinquent careers.

During this research period the writer had contact with many of the social agencies and most of the organizations dealing with delinquency and was in a position to observe the delinquents' attitudes toward these institutions. The writer was able, through this delinquent gang, to meet many other delinquents from other areas, and to be accepted on the basis of what is described, in their parlance, as "An O.K. guy." In brief, this research program resulted in familiarity with the neighborhood situation, its relationship to the delinquent activities, attitudes, knowledge of criminal techniques, and philosophies of life of the delinquent boy.

Gradually the writer familiarized himself in a somewhat similar manner with other areas, as had been done on the near west side, and material of a comparable nature was secured.

When the writer became a member of the classification board he was keenly aware of the formal relationship which usually existed between the in-
mates and the professional examiner. He remembered how, when employed in a research capacity, he had observed delinquents lying and blocking the diagnosticians. He was aware of the attitudes of the delinquent gang boy toward the professional staff. In cases from the west side gang, formal diagnosis had been compared with confidential knowledge of attitudes and past behavior. The discrepancies in most of these cases were amazing.

The research material was molded into a sociological interviewing technique. This technique functioned rather effectively in breaking the barrier of passive resistance and lying which is typical of the gang boy. This approach served to produce a more responsive, complete, and valid picture of the basic attitudes and the social factors operating in personality formation. The inmate's conception of himself, his values, objectives, philosophy, and general behavior patterns were more readily apparent than in the usual formal interview.

First, no difficulty was experienced in the cases of delinquents whom the sociologist knew personally. It is interesting to note the formal record in this case as compared to the diagnosis. This inmate upon admission to the penitentiary denied his guilt. The formal criminal record showed only one item. The inmate is here under an alias; therefore, no more of his formal criminal record was known, since the juvenile corrective institutions do not fingerprint their inmates.

CASE 1

*Criminal Record:*
St. Charles State School, Burglary, 1931–32.
Chicago—Cook Co. School, Burglary, 1929, escaped.
House of Correction, 1933, Attempted Larceny of Auto.
50 Arrests and 2 Violated
Paroles.
Many Cases were Fixed.

*Community:* This inmate was raised on the near west side of Chicago in a very deteriorated area, which is well known for its consistently high rate of delinquency. The sociologist has made an intensive study of this community. Criminal traditions and well integrated delinquent patterns of behavior are characteristic of this area. Delinquent gangs are very prevalent. Delinquency and crime exist to the extent that the probabilities are quite high that most of the boys coming from that area are either delinquents or have participated in delinquency at some time.
**Personality:** The sociologist knows this inmate intimately. His true criminal record is in this report. This inmate admits his guilt on the present charge and on a number of other serious crimes.

When this inmate was quite young he became a member of a delinquent group. Initiation into delinquency then began as a form of group behavior. He soon came to the attention of the Juvenile Court authorities and was supervised. Then followed a series of commitments. The commitments had the following outstanding results.

1. Increased stimulation, development and reinforcement of delinquent attitudes.
2. Contacts were made with delinquents from other parts of the city. These contacts were renewed upon release with consequent increase of the geographic range of this inmate’s delinquent acts.
3. No change of behavior, such as from delinquent to social behavior, is noted.

It is interesting to note that when committed, this inmate adjusted perfectly to the institutional routine. He was awarded a trophy one year as being the best behaved inmate in a correctional institution.

The inmate has pursued a delinquent career which is typical of his community. Petty theft, truancy, burglary, helping to loot accessories from autos stolen by older members of the area, larceny of auto, armed robbery, and bank robbery. Well steeped in criminal traditions and fixed criminal attitudes. He will adjust within the institution because, quoting the inmate, “The smart hood goes along so he can get out, only the dummies make trouble.”

Inmate frankly states he is continuing his criminal career after release. This inmate is unquestionably a recidivist despite his apparently youthful age.

If the inmates were not known personally to the sociologist, usually friends of the inmates, or friends of friends of the inmates, were known. This is the result of a very wide acquaintanceship with many delinquents, as was noted previously. To illustrate, consider case II. This inmate had a former criminal record consisting of one commitment to a juvenile institution. He denied previous criminal activities and was very resistive during the initial stages of the interview. Partial rapport was obtained when the examiner mentioned names of friends of the inmate. After the sociologist injected unofficial
data known only to the delinquents of a certain area, the response finally was, “Well, if Charley told you all that, you're O.K. with me too.”

CASE II

Family: The inmate is the youngest of five siblings. The parents were born in Italy, while the children were all born in Chicago. Upon their arrival in the United States, the parents came to Chicago and settled on the near-west side of the city. Due to culture conflict, primary group disorganization resulted. In a relatively short period of time we note a complete collapse of parental ties and control, which is quite characteristic of the family situation in this community. The younger generation spends most of its time on the street in this area. Participation in activities outside of the home soon reaches an extreme where the home in many cases becomes just a place to eat and sleep. The home cannot compete with attractions offered by what is termed here the “Street Life.” The desire for new experiences can be more adequately satisfied by the delinquent gang than the home. A broken home situation resulted due to the mother's death in 1920. We find that an older brother of the inmate is at the present time incarcerated in the institution. The economic situation was such that relief was requested from public agencies.

Education: This inmate attended elementary schools to the third grade, leaving school at the age of 12.

Work Record: This inmate has no work record.

Criminal Record:

1924 — Parental School, truancy.
1925 — Chicago–Cook Co. School for Boys, Burglary (escaped).
1926 — Chicago–Cook Co. School for Boys, L. of Auto (escaped).
1926 — Chicago–Cook Co. School for Boys, L. of Auto (escaped).
1926 — Chicago–Cook Co. School for Boys, Burglary (escaped).
1927 — House of Correction, L. of Auto.
1929 — Pontiac, Attempted Burglary; Discharged in 1933.
Approximately 100 Arrests

Community: This inmate resided on the near-west side of Chicago in an area which is well known for its criminal traditions and delinquent patterns of behavior. The prevalence of delinquent gangs and criminal cliques has made this community notorious. This area has shown a consistently high rate of delinquency. Research in this community has indicated rather regular successive graduations in the delinquent careers typical of this community.
Personality: When this inmate was quite young he was initiated into delinquency as a form of group behavior. Truancy resulted very shortly. The inmate continued to get into further difficulties with the result that he was constantly being supervised by the Juvenile Court. A glance at the criminal record will indicate the continual and consistent commitments that this inmate has undergone. Confinement in juvenile corrective institutions appears to have served only the purpose of increased development of delinquent attitudes. While committed to these institutions this inmate contacted delinquents from other parts of the city, with the result that he began to participate in delinquent activities in other parts of the city. He was very intimate with many well-known criminal personalities in his community and complete familiarity is displayed with the criminal tradition and techniques, which are characteristic of this area. Because of the sociologist's knowledge of many of the inmate's friends an unusual amount of rapport was secured, with the result that the inmate spoke very freely in a most vivacious manner and made no pretense of reformation. He admitted guilt on some rather major serious crimes. This inmate has pursued a regular developing criminal career. He has constantly engaged in criminal activities. A criminalistic philosophy in which anti-social objectives are characteristic plus fixed criminal attitudes would classify this inmate as a recidivist.

The utilization of intimate anecdotes and unofficial accounts of many activities, known only to delinquents of particular communities and the examiner, rapidly changes the interviewing relationship from one formal in nature to one that is informal and marked by an unusual degree of rapport. A potentially diagnosed first offender undergoing this approach received the following diagnosis:

CASE III

Criminal Record: The inmate's criminal record consists of two charges, both of carrying concealed weapons. He served a rather brief period of time in the Bidewell in Chicago in 1929 on the first charge and in 1930 on the second charge. These charges are rather serious in lieu of their indicating the behavior of the inmate during this period. He bragged to the sociologist regarding the manner in which he had put the "fix in."

Community: The inmate was born and raised in a community which is notorious both for its high rate of delinquency and the
criminal traditions which characterized the community. Traditions of delinquency and crime, and the various modus operandi of the latter, are transmitted from the older generation to the younger generation, such as social customs are in other forms of society. The idealization of the criminal, the fixing of the judge, the shyster lawyer, the intimidation of witnesses, the bribing of public officials, each form distinct configurations in the cultural pattern of this community. The sociologist is very intimate with this community and knows many of the friends of the inmate. He knows many of the criminal practices that are engaged in, and the activities of the members of the delinquent groups that exist in this community. The community factors may be regarded as being most unfavorable.

Discussion: This inmate has a casual work record and a poor educational background. He comes from a disorganized family and the community and marital factors in this case are unfavorable. His life pattern has consisted of successive delinquent experiences, accompanied by a gradual development of delinquent attitudes until at the present time the sociologist regards this inmate as having a well integrated anti-social personality. He possesses a completely anti-social philosophy of life and is well steeped in corruption and criminal objectives.

A display of complete familiarity with the physical features of the inmate's community, personalities in the area, and the rendezvous of the inmates has rapidly changed the interview from a formal one, characterized by cautious answers to the examiner's questions, to a vivacious, responsive, illuminating, and cooperative relationship. The approach in a sample case proceeded along the following channel. It opened with a statement from the examiner similar to this, "Aw, I've seen you before at Zimmermans and you had Stella there that night." The newly committed inmate, miles away from home in a strange penitentiary, who suddenly meets some person who knows such intimate details of his community usually responds with an excited flow of conversation. This initial establishment of a free informal relationship becomes less constrained as the sociologist injects more details and displays a comprehension of the inmate's discussion of his local community. Final barriers are usually broken when the inmate discovers that the sociologist was a pall-bearer for Lefty Petruchio, and knows the inside story of why and how Lefty was killed. Usually the response at that time is, "Well if yuh was O.K. wit Lefty you're O.K. wit me. What do yuh wanna know?"

Now what was the actual known basis for the opening statement, "Aw, I've seen you at Zimmermans and you had Stella there that night"? The prob-
abilities are that the writer has never seen the inmate there, or if he has, he has forgotten it. However, since we know that the inmate has resided in a particular community his entire life, the probabilities are overwhelming that, at some interval, the inmate has visited this particular restaurant. From our knowledge of this particular area we know that a girl by the name of Stella is notorious because of her sexual activities with most of the delinquents in the community. Therefore, we are on fairly safe grounds in using those data too. The diagnosis resulting from this approach, then, becomes radically different from what one would expect by judging from the formal criminal record.

CASE IV

*Criminal Record:* The inmate's criminal record is confined to two known commitments, one to the Chicago Parental School, and the other to the St. Charles School for Boys. However, a careful scrutiny of the police record is quite significant as regarding his criminal activities, as for example: 7-3-33, Robbery Charge—Nolle prossed because complainant was not in town; 10-5-33, Robbery—Nolle prossed because witness not sure, etc. This inmate has been arrested 25 times.

*Community:* This inmate was raised in a very deteriorated area which is predominantly Italian in racial composition. This area has a very high rate of delinquency and is well known for its criminal tradition and the criminal patterns of behavior that have permeated the culture of this community. Delinquent gangs and criminal patterns of behavior are outstanding characteristics of the culture of this community.

*Personality:* A very unusual degree of rapport was established between the sociologist and the inmate. The sociologist is very familiar with the community, friends, and ideology of this inmate and his associates. During the interview the inmate admitted his guilt of many well-known robberies in the city of Chicago including crimes of major seriousness. He named several associates that accompanied him on these criminal activities. A check was made with these associates that confirmed the inmate's accounts of his criminal activities. We have here a case of the typical very sophisticated delinquent gang boy, the product of a disorganized area of a very high rate of delinquency. Very well developed criminal attitudes and criminalistic objectives and philosophy of life. In brief, the anti-social trends of this inmate's personality are so marked that he may be termed anti-social.
Many potential first offenders (with no previous formal criminal records) have rather quickly become admitted experienced criminals by analysis of criminal techniques. The particular case cited here is of an inmate committed on a charge of larceny of an automobile. During the formal interview the inmate, with a display of emotion, denies having committed crimes previously and states that this is the first auto he has ever stolen. He is quizzed as to the technique employed in unlocking the auto. He replies, "With a master key." From our research background of delinquent activities and patterns of typical sequence of techniques in that community, we know that most of the delinquents become proficient in the use of a master key only after stealing a number of cars. This is usually preceded by episodes of burglary. The sociologist, acting on this clue, probes and frankly tells the inmate why he is skeptical of his denial of all previous delinquent activities, and that he is aware that the inmate has passed the novice stage. With very few exceptions the inmate then unfolds a lengthy previous history of delinquencies. The following diagnosis results.

CASE V

**Criminal Record:** Chicago–Cook Co. School, 1927; St. Charles, 1929, Larceny of auto.

**Community:** Deteriorated, low rental area in which delinquency is very prevalent. Delinquent traditions and gangs are outstanding characteristics of this community.

**Personality:** This inmate has consistently followed a criminal career which is typical of the delinquent pattern of behavior of his community. He has become so proficient in stealing autos that he became affiliated with the automobile syndicate in Chicago located at C— and D— Streets. He has stolen more than 200 cars in the past two years. When arrested on this charge he was promised protection by the syndicate. He states he failed to be acquitted because of the crime drive that was in full force at that time. Unusual rapport was attained when this inmate discovered that the sociologist knew a number of the inmate's friends and also knew the true unofficial versions of certain things known only to the delinquents of that community. At that time the inmate stated, "Y'know I'm through fooling with shorts (cars), from now on I'll get other punks to get the shorts and I'm going into business." Well-grounded criminal attitudes and anti-social philosophy. Recidivistic material.

Knowledge of the typical sequence of delinquent activities in the history of the delinquent career is a valuable phase of this approach. It is known (from
research) that most criminals, from certain communities, have pursued a regular developing delinquent pattern before reaching the stage of robbery or even larceny of an automobile. Data pertaining to these delinquent careers permit a pointed positive interview approach that is rather successful in procuring a valid picture of the inmate's behavior. A case is given where this approach was used.

This inmate, during the initial stages of the interview, denied his guilt. Great resistance was encountered in attempting to secure any material relating to previous delinquencies. A partial rapport was secured when the writer discovered that he had known some of the inmate's friends when they had been incarcerated in a juvenile corrective institution. On the basis of partial rapport the inmate admitted his guilt on one previously known official commitment. However, considerable blocking was still evident. The approach just described, which is based on the typical sequence of delinquent activities of certain communities, was then projected. The inmate's probable past delinquent career was reconstructed including probable commitments. Attention was most scrupulously centered on detail. For example, research shows that the burglary stage of the delinquent career of that community is generally the same. By that we mean the young delinquent burglarizes a particular type of store. Details of this nature resulted in astonishment, then indignant denial which was shortly followed by a series of admissions including a number of juvenile commitments and gang associations. The personality diagnosis resulting from this approach follows:

CASE VI

*Criminal Record:* An extensive Juvenile Court record is present in this case. Commencing with truancy, the inmate was in rapid succession committed to the Parental School twice and later twice to the Chicago–Cook County School for Boys—both times on charges of burglary. In 1929 he was committed to the St. Charles State School for Boys on a charge of burglary. In 1932 he was committed to the House of Correction in Chicago on a charge of larceny of an automobile. His criminal record is also characterized by two probations, one of which definitely was violated, and two escapes.

*Community:* Community factors may be termed as being distinctly unfavorable. This inmate was raised in a deteriorated area, which is characterized by rooming houses, vice, general disorganization and one in which delinquent gangs are prevalent.

*Personality:* This inmate was initiated into delinquent activities at a very early age. He first participated in delinquencies as
a form of group behavior. This resulted in truancy and general behavior problems. Repeated commitments have failed to alter this inmate’s behavior in any marked manner excepting insofar as it has resulted in reinforcement and continuing development of delinquency attitudes. He has constantly followed a consistent developing criminal career. Truancy, petty thievery, burglarizing of stores and larceny of automobiles followed in regular chronological order. The inmate and his group first became involved in stealing automobiles when they reached the decision that they could utilize an automobile in their various burglaries so as to increase their profits. This inmate frankly admits that the odds are 9 to 1 that he will continue to engage in criminal activities. Fixed criminal attitudes and anti-social objectives are apparent in this boy. Since previous institutionalization has not affected this inmate’s delinquent behavior, it is quite dubious as to whether the present incarceration will result in any change; however, a superior intelligence as attested to by formal psychometric data (B-113) and a somewhat promising degree of insight appears to indicate therapeutic possibilities.

The usage of delinquent vocabularies characteristic of the inmate’s community is of great value in the establishing of closer rapport. To illustrate, if the question, “Have you ever been chased by the police while you were in a stolen car and have the police shot at you” is phrased “Have you ever been in a hot short and got lammed by the heat and had them toss slugs at you,” a warmer and more responsive answer usually results. Furthermore, the usage of delinquent terminology may serve as a criterion in analyses of degree of development of delinquent attitudes.

The main trends of the approach utilized in this interviewing technique have been described in the preceding material. As the reader may deduce, there are innumerable detailed points of information which may be used in attempting to probe through a resistant hostile barrier. For example, an inmate is committed on a charge of armed robbery. He denies previous criminal activities and parries all queries. He states he was unemployed, penniless and therefore victimized by the police. A slight detail, such as the name of his attorney, may result in the securing of a good deal of material pertaining to his past life. The writer knows that the inmate’s attorney’s minimum retainer fee is $250. Under cross examination the inmate admits he has money and has engaged in armed robbery for a period of two years.

It has been suggested that the necessity for first hand research in order to utilize the above technique might be obviated by the acquisition of various key stories, names, or factual fragmentary information. The examiner, however,
would encounter a great deal of difficulty in attempting to secure this form of unofficial information because of the formal professional relationships existing in the penitentiary. The general suspicion and resentful awareness of inmates is not conducive to obtaining data of this nature.

Assuming, however, that such data could be secured, the examiner will face another difficulty. After opening the interview on the basis of such data, and along the general trends described in this paper, he will probably secure an initial responsive cooperation. In a relatively brief period, however, he realizes that more and more material must be injected, not only to reinforce the secured rapport, but to retain it. The inmate, becoming aware of fewer responses and total ignorance displayed by the examiner on many points, begins to suspect he is being tricked. He commences to wonder why, if the examiner knows the inside story of the X robbery, he doesn't know J., who participated in that crime. Many inconsistencies soon appear and the inmate becomes panicky. Complete blocking usually results.

The statement may be made that most of the material produced by utilizing this approach is factual in nature and is not very penetrating as regarding personality analysis. An intelligent scrutiny will rapidly disclose the weakness of a criticism of that nature.

First, in the major part of the interviews in which a highly unusual degree of rapport is secured, a more accurate and valid portrayal of the attitudes, objectives, conceptions of the self and causative factors in delinquency is obtained than in the formal interview.

Secondly, we have the group where the technique is used to probe through a resistant barrier. In this group a comprehensive, valid knowledge of behavior is highly illuminating as to an understanding of the development of attitudes and general personality configurations. The close inter-relationship between attitudes and activities is not to be denied.

The sociologist, by the development and utilization of this technique, does not see the inmate as an isolated unit nor does he possess a cold, formal knowledge of the inmate's social milieu. He knows from first hand contact and study the social phenomena of the inmate, including those subtle phases of the total picture which are so highly significant and yet which must be learned through first hand contact. When studying the gang boy it can be generally stated that: To know your community is to know your delinquent.

With this background and technique a truly gestalt picture is secured. The sociologist is in a position to portray and interpret the interplay of attitudes, group customs as related to habits, social distances, conception of the self, and an insight into the motivations and dynamics of behavior that will be a contribution to criminological units.
NOTES

1. This study was made under the supervision of C. R. Shaw—Institute for Juvenile Research, Chicago, Ill.
2. All care has been exercised to remove any identifying data from the case illustrations in this paper.
Community Analysis and Organization

Saul D. Alinsky

ABSTRACT

In the industrial area adjacent to the Stock Yards of Chicago, a community council was formed which included the two basic institutions of the area — (1) organized religion and (2) organized labor — as well as all of the other interest and action groups in that community. "Back of the Yards Neighborhood Council" is an experimental demonstration of a community organizational procedure predicated upon a functional conception of the character of a community and its problems. On the local scene the council has operated a successful program. It has brought about not only a tangible improvement in the way of life of the local residents of Back of the Yards but has also resulted in the development of an unusual sympathy and understanding between organizations which previously had been in opposition and conflict. This Council has not confined its efforts to the local scene but has also addressed itself to the task of coping with those larger socioeconomic issues which converge upon the local scene to establish the plight of Back of the Yards. The Council is aiding other industrial areas to organize in a similar manner in the hope that the combined strength of many such community councils will be sufficient to deal effectively with these major destructive forces.

Community organizational enterprises have traditionally confined themselves to co-ordination of professional formal agencies which are, first, superimposed upon the community and, second, play a superficial role in the life of the community. It is a rare phenomenon today to discover a community organization in which the indigenous interest and action groups of the community not only participate but also play a fundamental role in that organization. Even where the possibility of organizational work of this character has evidenced itself, it has not been accompanied by any significant understanding of the social forces involved in the functional nature of a community or of the socioeconomic strata of the community and its corresponding implications.

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The two major defects in the traditional community organization movement are (1) that it views each problem of the community as if it were independent of all other problems and (2) that it views the community as a social, political, and economic entity which is more or less insulated from the general social scene. This appears to be true both of those agencies which are concerned with some one special problem of the local community as if this problem were isolated and of those which claim to be interested in the development of a program for such a local neighborhood as a whole, without recognizing that the life of such a neighborhood is shaped by forces which far transcend the local scene.

An understanding of the fashion in which a local community functions within the larger social organism demands a marked departure from the conventional procedures characteristic of that kind of communal organization which proposes that the community elevate itself by means of its own bootstraps. It means that, while the community as a whole is taken as a specific starting-point for a program of social construction, the organizational procedures must direct their attention toward those larger socioeconomic issues which converge upon that scene to create the plight of the area.

In this paper it is proposed to discuss very briefly and generally an effort now being made to project these considerations into a concrete situation. I propose to indicate an employment of the foregoing philosophy in the formation of a community council.

Among the many neighborhoods whose names have been synonymous with certain characteristics responsible for their reputation, such as "Hell's Kitchen" and "Harlem" in New York City, there is none which stands out more conspicuously than that part of the city of Chicago known as "Back of the Yards." This is "The Jungle" of Upton Sinclair. Colorfully dramatized in American literature, immortalized in poetry, "Back of the Yards" has come to be in the eyes of the American people a byword for disease, delinquency, deterioration, dirt, and dependency. The history of Back of the Yards is to a large extent a study of the immigration movements to this country. It is a story graphically demonstrating the methods employed by a rapidly expanding industry in its drive to secure cheap labor. It is a history of the American "melting-pot" process. It is also the saga of organized labor in the United States. It reflects the history of the Knights of Labor, of the American Federation of Labor, and of the Congress of Industrial Organizations. It is a story of desperation, of surging enthusiasms, of violence, and of heartbreak.

A survey of the possibilities for community organization of the residents of the Back of the Yards neighborhood reveals two basic social forces which might serve as the cornerstone of any effective community organization which would, first, be representative of the people of the community and, second, by the very virtue of such representation, possess the necessary strength to effect
constructive changes in the life of the Back of the Yards neighborhood. These two elemental social institutions are, first, the Catholic church and second, organized labor.

More than 90 per cent of the population of the Back of the Yards community is Catholic in religion. It is the Catholic church which serves as the medium through which these people express some of their most cherished traditional hopes, desires, and aspirations. The Catholic church is an integral and dynamic factor in the experiences and lives of the people "back of the yards." In this area one finds a variety of nationalities. There are Poles, Lithuanians, Slovaks, Germans, Irish, Ukrainians, and Mexicans. The Poles constitute the dominant nationality group. The parishes are to a large extent composed of distinct nationality groups. For example, there is a Slovak church, a German church, a Polish church, a Lithuanian church, etc. In this particular neighborhood there are seven large parishes. It is common knowledge that, even though parts of the same denomination, these parishes have rarely acted as a unit in attacking community problems. Today, through the medium of the Back of the Yards Neighborhood Council, these parishes are operating as a solid bloc.

Just as the Catholic religion is the common spiritual denominator for the people of the community, so to a relative extent one finds in the neighborhood a common vocational denominator. To a large extent the economic life of this community depends upon the Stock Yards and its affiliated subsidiaries. If production falls off at the Stock Yards, the economic level of the people back of the yards correspondingly declines. If a man or woman in the community is not directly employed in the Stock Yards or in one of its subsidiaries, that person's wife or husband (as the case may be), or child, or relative, or neighbor, or friend, is, or has been at some time or other, employed in the Stock Yards. Organized labor unions not only represent the vocational interests of a large number of residents of the Back of the Yards community, but they also serve as the medium through which these people express their secular hopes and desires for economic security.

The major Back of the Yards labor union today is one large industrial labor union to which belong the vast majority of workers in the packing industry. This union is the Packinghouse Workers Organizing Committee, which is an affiliate of the Congress of Industrial Organizations. It is obvious that the membership of this union is very closely related to the membership of the Catholic church. The same people that comprise the membership of a parish also form the membership of a union local. It is quite common to find that a steward or member of the Packinghouse Workers Organizing Committee is also an official of a Holy Name society or another religious organization.

In recent months, after years of the ravages of depression, there has been developed a strong conviction among the various organizations in the Back of
the Yards community that, first, they are confronted by menacing, seemingly chronic social problems. These problems range through unemployment, disease, child welfare, delinquency, and poor housing. Second, these organizations have become convinced that if these problems are ever to be solved they must be solved by the local residents operating through their own organizations and institutions. Quoting from a recent program published by the Council:

For fifty years we have waited for someone to offer a solution — but nothing has happened. Today we know that we ourselves must face and solve these problems. We know what poor housing, disease, unemployment, and juvenile delinquency mean, and we are sure that if a way out is to be found, we can and must find it.

Operating on the basis of these convictions, the organizations came together and banded into the Back of the Yards Neighborhood Council. Their objectives are clearly presented in their statement of purpose:

This organization is founded for the purpose of uniting all of the organizations within that community known as the Back of the Yards, in order to promote the welfare of all residents of that community regardless of their race, color or creed, so that they may all have the opportunity to find health, happiness, and security through the democratic way of life.

With the possible exception of some of the smaller organizations maintained by outsiders in the community, almost every person in that area is affiliated to one or more of the organizations which are represented in this community council. It is significant to point out that the earnestness and enthusiasm of the Catholic church is illustrated by the fact that, instead of sending nominal lay representatives to the Council, the priests have personally assumed membership. Similarly, the chief officials of all the other organizations are personally participating in the Council.

The Back of the Yards Neighborhood Council today represents the church, labor unions, both C.I.O. and A.F. of L., the local chamber of commerce, the local American Legion post, the leading businessmen, the social, the nationality, the fraternal, and the athletic organizations of the people "back of the yards." The Chicago Park District has played a dynamic role in the Council as reflected through its local park director, an indigenous leader in the community and one whose aggressive leadership was a highly significant factor in the organization of the Back of the Yards Neighborhood Council.

It can be seen that the Council is not simply a group of well-meaning individuals, nor is it merely representative of one or two segments of the com-
munity. Above all, it is not an organization controlled by outside groups whose basic interests are, in the final analysis, either not identical with or opposed to the objectives sought by the people "back of the yards." The Council, rooted primarily in the fundamental institutions of the community, now includes practically every organization of significance in the life of the Back of the Yards community.

Its program is carried on by eight committees. Each committee has its elected officials who in turn compose the executive board of the Council. The personnel of the executive board as well as of the various committees is of such an indigenous character that through their experiences (in some cases life-long) and associations in the community they have all acquired a vast fund of intimate knowledge regarding those subtle, informal, and personal aspects of the communal life of Back of the Yards. This is the type of intangible information that cannot be uncovered by formal surveys or studies. The procedures and methods utilized by the Council all stem from this body of personal, informal, intimate data. The objectives of each committee, as well as their composition, clearly reveal the issues of the area as defined by the local residents. A study of these issues is of the utmost significance in understanding why so many organizations seemingly opposed in their programs and objectives nevertheless united. For example, during an early Council meeting the representative of the local chamber of commerce bitterly complained about the problem of unemployment. He emphasized that the price of unemployment was borne in the main by business because of the high taxes for public relief. The labor representative disagreed with this view, pointing out that an unemployed man cannot pay union dues and is a constant drain on the union benefit fund. The religious representatives then interrupted to emphasize that an unemployed man cannot contribute to his church, and, lacking these contributions, the churches could not sustain themselves. After prolonged discussion, they reached the conclusion that the disastrous effects of unemployment were borne by all in common. The blunt fact is that common grave problems presented a fundamental threat to the welfare of all the people "back of the yards" and all of their organizations. Issues such as unemployment or disease are fundamental threats to the welfare of labor unions as well as to business dependent upon the purchasing power of that community.

Therefore it is understandable why, on the committee for unemployment or on the committee for a higher standard of living or on the health committee, one finds represented the leading local businessmen, labor leaders of both the C.I.O. and the A.F. of L., Catholic priests, police officials, leaders of nationality, social, and athletic groups — all putting their heads together and pooling all their efforts and collective skill toward the solution of their common problem. This common immediate stake for church, business, and labor transcended doctrinal differences and has resulted in the development of an
unusual understanding among them. It is this unity of purpose, this organized sentiment and opinion, that generates an almost irresistible force and explains the record of achievement and speed of accomplishment of the Back of the Yards Neighborhood Council. Because the Back of the Yards Neighborhood Council represents the mobilized sentiment of the community as articulated through their indigenous organizations, it is not only a community council but a movement. The fact is that, when a community is organized so that it moves, it becomes — a movement.

The final authority of the Back of the Yards Neighborhood Council is lodged in a community congress which meets on a minimum of twice a year; elects officers, amends by-laws, ratifies or disapproves policies, and acts upon all matters referred to it. The community congress consists of one representative for each twenty-five members of each member organization of the Council in good standing. This community congress insures control of the Council by the people. The following is the program achieved by the Council during the last eighteen months.

1. An infant welfare station has been secured.
2. A contract was signed whereby the Back of the Yards Neighborhood Council secured a large section of land in the neighborhood for the purpose of creating a community recreational center. An all-community recreational center is now in the last stages of construction.
3. Within five months the Back of the Yards Neighborhood Council became recognized by the Community Fund of Chicago, secured an allocation, and became a participating agency in the fund. Now in its second year, the Council's allocation has been doubled.
4. A survey is now being completed of specific immediate needs of the community so that they may be met as quickly as possible.
5. On the subject of relief, the Back of the Yards community was singularly articulate and unanimous in waging the fight for adequate relief standards. It has exerted constant pressure for the support of humane relief standards for those in need of relief. It has carried its fight to the state as well as to the national capital.
6. Negotiations are now under way regarding a possible housing project.
7. More than 2,800 jobs were secured through the co-operation of both the National Youth Administration and private industry.
8. A delinquency subcommittee has been created which comprises representatives of various organizations. This committee investigates each case of juvenile delinquency, then takes appropriate action. If unemployment of a parent of a delinquent boy appears to be a contributing factor to that boy's delinquency, then some kind of job is secured for that parent.
9. A community-owned dental clinic is now being set up to provide free dental service for all children under thirteen years of age whose families are unable to afford such care.

10. Arrangements were concluded between the Back of the Yards Neighborhood Council and the owners of the local weekly community paper whereby a special board of governors appointed by the Back of the Yards Neighborhood Council have complete jurisdiction over the character and policy of the local weekly paper. As a result, the community today has a newspaper which they write, edit, and read themselves — a journalistic organ reflecting the interests, attitudes, and aspirations of the people of the community rather than of an extremely small segment of the population of the area.

11. A general community improvement project is now under way to convert all empty, dirty, vacant spaces into little individual parks with grass, trees, and attractive facilities, offering places for the workers and their children to relax.

12. Following the example of their elders, the youth in the community have organized their own Back of the Yards Neighborhood Youth Council, and for the first time the youth groups of the community are engaged in a coordinated, constructive, well-organized program for the solution of their problems.

13. An agreement was reached between the Back of the Yards Neighborhood Council and the Federal Surplus Commodities Corporation whereby 1,400 children are fed one hot meal every day of the year. A portion of the expense of this food project is carried by the Back of the Yards Neighborhood Council. The project was instigated by the youth organization, which bears the slogan "Not Only Bat and Ball but Bread and Butter."

14. The Council has sponsored a great many affairs, such as boxing shows, carnivals, dances, fairs, and various other forms of community get-togethers. All proceeds from these events have been utilized for the Council program. Here is a demonstration of where the people in the community pay admission for entertainment to their own community affairs and then have their own money turned back to be used in their own general welfare program.

15. The Council is now in the process of purchasing a large summer camp site out in the country. The camp facilities will be constructed and developed by the local people themselves, and it is their desire that every child "back of the yards" shall enjoy the advantages of a summer-camp vacation for at least two weeks of the year. The camp will be owned and operated completely by the community.

16. Recently the Back of the Yards Neighborhood Council sponsored a community fair at which they had a large exposition tent. In this tent individual merchants and organizations rented booths for the purpose of advertising their wares and also to indicate their allegiance to the Neighborhood
Council. The spectacle of the C.I.O. booth adjacent to that of the chamber of commerce, and the Democratic and Republican parties sharing adjoining booths, was a vivid demonstration of the new spirit of democracy which has pervaded the culture of “back of the yards.”

17. A community credit union is now being financially underwritten through definite agreement with all the major institutions of the community whereby they will purchase shares in this enterprise. This community credit union is the Council’s major project for this year. The Council regards this credit union as one of its most important weapons in its drive for the economic security of its people.

To most observers the intangible achievements of the Back of the Yards Neighborhood Council have been of far greater importance than its tangible accomplishments. Through the medium of the Back of the Yards Neighborhood Council, leaders in various interest and action groups have learned to know one another as human beings rather than as impersonal symbols of groups which, in many cases, appeared to be of a hostile nature. The personal relationships which have been developed have to a large degree broken down that urban anonymity characteristic of all such communities. Furthermore, we today find an independent philosophy developing back of the yards which can best be described as a people’s philosophy.

A revealing demonstration of this type of social relationship is to be found in some of the recent activities of the constituent organizations of the Back of the Yards Neighborhood Council. For example, some months ago when the C.I.O. held a picnic, the local chamber of commerce took the lead in securing advertisements for the C.I.O. picnic program book. Similarly, a few weeks later when the local chamber of commerce embarked upon a membership drive, the C.I.O. leaders not only assisted the chamber of commerce membership committee but publicly informed local businessmen that it was their duty to be members of the local chamber of commerce. This community solidarity does not rest completely upon any special benevolence on the part of the members of the Council and the organizations for which they speak but upon the clear recognition that to a large extent they either stand or fall together.

The position assumed by the Council in a number of crises of impending conflict between labor and capital has caused many observers to characterize the Back of the Yards Neighborhood Council as “pro-labor,” sympathetic to the C.I.O. The point of view of the Council on organized labor is quite clear. First, it looks to the national organized labor movements to cope effectively with many of those major social forces which impinge upon the Back of the Yards community with disastrous results. Second, the Council fully recognizes the important role of organized labor in the drive for economic security and
the improvement of those conditions under which people work. The philosophy of the Back of the Yards Neighborhood Council is that a community organization which does not improve the economic life of its community cannot become a really significant force in the lives of the people. The Back of the Yards Neighborhood Council concedes that constructive work within limits can be done without reference to the economy of the community. But until the economy of that community is significantly changed, until the problem of economic security is dealt with, one actually has the paper decoration one finds at the end of lamb chops — but no lamb chops.

From the inception of the Back of the Yards Neighborhood Council, organized labor began to participate actively despite that skepticism and profound distrust which has caused labor to refer to welfare work as "helfare work." The grave reservation which labor has maintained toward most social welfare programs and agencies was and is based upon certain fundamental contradictions underlying the field of social welfare. Labor recognizes that practically all private social-work agencies are supported and governed by those very same persons whose activities in the industrial world have, in many cases, not only laid the foundation for many of our social problems but who, by the very nature of a large part of their pursuits, tend to perpetuate those very conditions which in their philanthropic life they profess to be combating.

It is therefore understandable why in a union-conscious community many of these welfare agencies have come to be regarded and defined as "company social-work agencies." Members of company unions request favors. Members of bona fide unions request their rights. Therein lies a partial explanation of the recent introduction and development by the Back of the Yards Neighborhood Council of the concept of "rights" as over and against the prevailing antiquated welfare motif of "benevolence."

That this shift of emphasis from "favors" to "rights" is a marked departure in the philosophy of community organization is obvious. The organizations and institutions of the people "back of the yards" feel that the only way they can get their rights is through a community organization which is built, owned, and operated by themselves rather than by outside interests which in many cases are basically opposed to many of the fundamental objectives which these people want.

In recent times the people "back of the yards" have become vitally interested not only in the problems of their own community but also in the problems of the state, as well as in national issues. This growing recognition on the part of the people back of the yards of Chicago that many of their problems stem from sources far removed from their own community has been one of the most fundamental developments and achievements of the Back of the Yards Neighborhood Council and has been manifested in their interest in a national housing program, the national health program, the policies being practiced by
their political representatives, the development of a common curiosity regarding the reasons pro and con of national programs, the inquiries of people about the congressional records, etc.

This broad realization by the Back of the Yards people that their problems are not peculiar unto themselves and that their community is not a little world by itself is responsible for the interest and assistance of the Back of the Yards Neighborhood Council in the organization of similar community councils in the other industrial areas of the nation. They believe that only through the combined strength of many such organizations can they hope to cope effectively with those major destructive forces which pervade our entire social order. Their problems are the same, the causes of their problems are the same, and the organic character of these industrial communities is very similar.

If the fact of a disorganized community is in any way symptomatic of underlying and pervasive processes, then recreation or any other segmental activity which is held out as a panacea must be regarded as limited in its possibilities. Similarly, it will be increasingly clear that the experiments with community organization on a purely local scale will prove themselves ineffectual. While the Back of the Yards Neighborhood Council is not held out as the nostrum for the reconciliation of irreconcilable conflicts, in its basic framework it may be regarded as suggesting the direction in which the problems of social life in complex societies can be met with greater hope of success than previous philosophies of community organization.
Saul Alinsky in Retrospect

John F. Glass

Saul Alinsky was the best known and most controversial community organizer in the country — he was also a pioneer clinical sociologist, as shown by the preceding articles on his career as a criminologist and a community organizer.

I became acquainted with the Alinsky family in the 1950s as a teenager in Chicago. A youth group I belonged to sometimes met at the Alinsky's South Side home on Woodlawn Avenue in Kenwood, a couple of miles from the community where Alinsky's The Woodlawn Organization (TWO) took on City Hall and the University of Chicago. The last time I saw him was in the spring of 1966 at a seminar I had organized for him at UCLA, where I was a graduate student in sociology. Alinsky was a charismatic figure, portly, with a deep and commanding voice, who could display both brilliant wit and biting sarcasm. He was a lightning rod for controversy. Yet, under his gruff exterior there was a deeply compassionate man who genuinely liked people from all walks of life.

His many friends included corporation president George Romney, labor leader John L. Lewis (whose biography Alinsky wrote), and the French philosopher Jacques Maritain. He even had the grudging respect of conservatives like William F. Buckley and some of the politicians with whom he battled.

No one was neutral about Saul; he had as many critics as supporters. Much of the criticism of his work from both in and out of academia focused on his tactics and his failure to link local action to larger movements for social change. Alinsky held a dim view of academics, particularly social scientists, whom he dismissed as little more than head counters. He was an agitator, a self-styled professional radical, an urban populist. He was not a Marxist, communist, or revolutionary, as his enemies often insisted. His friend Carey McWilliams, long-time editor of The Nation, characterized Saul as a brilliant tactician and a radical democrat, a splendid latter-day example of an enduring American tradition.

In his first book, Reveille for Radicals (1946), Alinsky laid out his ideas on how to protect democracy from dictatorship by creating people's organiza-
tions. He distinguished liberals from radicals: "Liberals protest; Radicals
rebel. Liberals become indignant; Radicals become fighting mad and go into
action." He was critical of 1960s radicals who did not believe in our political
system. His objective was to improve America, not tear it down. Rather than
overthrow existing institutions, Alinsky sought to make them more
democratic and responsive to people's needs. According to Charles Silberman,
author of *Crisis in Black and White*, "The only difference between Alinsky
and his enemies is that Alinsky really believes in democracy." Alinsky believed
that change comes only through **power**, which he defined simply as the **ability
to act** for the powerless that means organization. He saw that people do not
receive opportunities, freedom, or dignity as a gift of charity. These come
about only when people take them through their own efforts. Consensus can
come only after conflict.

In *Rules for Radicals* (1971), published the year before his death, Alinsky
wrote: "There can be no darker or more devastating tragedy than the death of
man's faith in himself and in his power to direct his future." He began this last
book by saying: "What follows is for those who want to change the world from
what it is to what they believe it should be. *The Prince* was written by
Machiavelli for the Haves on how to hold power. *Rules for Radicals* is written
for the Have-Not on how to take it away." "Mass power organizations" were
the mechanisms through which this change would be effected. Yet, as an
organizer, Alinsky started with the world as it was, not as he would like it to
be. Working within the system and using the status quo as his best ally were his
trademarks. His sometimes outrageous tactics became legendary; often the
mere threat of using them would get the power structure to capitulate. For ex-
ample, instead of filing housing complaints with the building inspector, the
community organization spearheaded by Alinsky would drive forty or fifty
black members to the suburban home of the slumlord to picket his house with
signs reading "Your Neighbor is a Slumlord." This was designed to exploit
racism (the status quo) for the community organization's ends. Predictably,
the slumlord's white neighbors would get after him, saying "We don't care
what you do for a living, but get these niggers out of here or you go." Repairs
were quickly made! This example also illustrates one of Alinsky's tactical prin-
ciples — the right things are almost always done for the wrong reasons.

Unlike some radicals, Alinsky never glorified the poor, on whose behalf he
worked. Being poor, he commented, is not very complicated. It means not hav-
ing any money. He also said that he had seen the have-nots become the haves
and become just as crummy as the haves they used to envy. Still, he believed
that this was their prerogative. He supported the right of the poor to aspire to and
choose the values or styles that many radicals saw as decadent.

Saul Alinsky grew up in the slums of Chicago, the son of poor Jewish im-
migrants. He lived in Los Angeles for a while after his parents were divorced,
and graduated from Hollywood High. He entered the University of Chicago in 1926, studying anthropology and sociology. His social action career dates back to his third year in college, when he and some fellow students became interested in a coal miners' dispute in southern Illinois. After graduating cum laude in 1930, Alinsky was awarded a graduate fellowship in criminology; after two years of graduate work at the University of Chicago, he left to work at Joliet State Prison.

Alinsky's dissatisfaction with psychological approaches to criminology formed the basis of his emphasis on local community groups as the locus for action to improve urban life. This emphasis on community carried over into the next phase of his professional life. In 1938 he turned down a position in Philadelphia as head of probation and parole and visiting lecturer at the University of Pennsylvania, and chose instead to organize the poor. His distinctive style and philosophy emerged from his experiences as a labor organizer for the CIO. He was a pioneer in adapting tactics from the labor movement — boycotts, picketing, and strikes — to community organization.

In the late 1930s Alinsky began organizing Back of the Yards, near Chicago's stockyards, one of the worst urban slums in the nation. Back of the Yards became a stable neighborhood and a model working-class community through his efforts. With the backing of two prominent Chicagoans, publisher Marshall Field and Bishop Bernard Sheil, Alinsky set up the Industrial Areas Foundation (IAF), which began to train organizers to apply the Alinsky method to communities across the country. Rochester, Kansas City, Buffalo, and Oakland are but a few of the cities where Alinsky's organizing efforts took place. In the late 1940s he supervised and aided Fred Ross in setting up the Community Service Organization (CSO) in East Los Angeles. It was through the CSO that Cesar Chavez, his best-known student, came to Alinsky's attention.

Toward the end of the 1960s, when whites were no longer as welcome in organizing blacks, Alinsky increasingly felt that no lasting reform was possible without involvement of a significant proportion of the middle class. He spent much time lecturing on college campuses, setting up a new school to train organizers, and promoting his shareholder proxy plan. Proxies for the People was a plan to solicit proxies to be used at stockholder meetings to pressure corporations to support such social causes as public transportation and the elimination of pollution.

Today, more than a decade after his death, Alinsky remains a controversial figure. His tactics have become commonplace among small neighborhood groups across the country. In Los Angeles, for example, the United Neighborhoods Organization (UNO) operates in the barrios largely on the Alinsky model of an issue-oriented mass membership organization to pressure business and government for change and action. The IAF still exists, but it is now based
In New York, and community leaders being trained there are becoming increasingly influential politically.

In a recent article Donald and Dietrich Reitzes (1982) suggest that Alinsky's work is as important today as it was in the 1960s. They feel that Alinsky's own impatience with formal theory and research hindered attempts to explore his underlying sociological orientation. They conclude their assessment of Alinsky's writings and community organization work with: "Alinsky remains a marvelous example of the sociological imagination and the creative application of a sociological perspective."

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Saul Alinsky: A Recollection

Jonathan A. Freedman

At the time of our encounters during the 1960s, I certainly did not see myself as a clinical sociologist and Saul Alinsky had almost no patience for those with academic pretensions. In retrospect, I see that some but not all of Saul Alinsky's approach fits with clinical sociology as it now is emerging. He emphasized a set of rules for community organizing based on the value of empowerment — "power to the people." As a basis for strategy, he used a practical sociological model that emphasized conflict between social classes: the powerful with their elite organizations versus the poor with their citizens' organizations. He used a sociogram approach to discover natural leadership for his organizations. He understood and used racial and ethnic factors as keys to organizing. He had a sense of social change, with his effectiveness coming from a careful building of an organizational structure based on the involvement of the grass roots.

I had watched Saul Alinsky from a distance a few years before I met him. I was involved in street-corner juvenile delinquency research when the Industrial Areas Foundation directed by Alinsky was in the midst of creating community organizations in Chicago: northside, southwest side, and then a powerful black organization, The Woodlawn Organization (TWO). My closest friend, Sol Ice, became a community organizer in Woodlawn; frequently, he and other organizers, including Nicolas Von Hoffman (now a syndicated columnist), came by my apartment late in the evening after long days and evenings of work.

I learned about strategy secondhand, but I learned also about a master strategist who usually had the respect of his organizers, who knew how to build powerful coalitions. I was a delegate from a specially created white organization to the founding convention of TWO. There I saw Saul Alinsky for the first time. To me he was a master composer, not on center stage but off to one side, orchestrating the convention, with his staff of organizers working closely with (or perhaps manipulating) members of a poor community, molding them into a powerful structure with leadership that he would clearly
influence or possibly control. I did not meet him in Chicago. I was intimidated by his power and the controversy that surrounded his methods.

The first paper I wrote as a graduate student in the Department of Sociology at Brandeis University was on community organizing and power, using what I witnessed in Chicago as material. Four years after that an opportunity arose to be a senior researcher on a poverty program project using the Alinsky model to train community organizers and create people's organizations in Syracuse, New York. Alinsky was to be the consultant and major instructor on this project, the Community Action Training Center of Syracuse University. When I finally met him in the project office, he had just finished talking with a member of the research staff whose presentation of self was somewhat unusual. His first salvo after a brief introduction was, "Under what rock did you find your staff?" I tried to justify the value of this staff member from a "one down" position but to no avail.

The Community Action Training Center was surrounded by controversy. One problem was that trainees could not see the relevance of the training they were receiving from Alinsky. He taught practical empowerment through community organizing, but he used as a reference point the setting of Back of the Yards, a Chicago community that he organized before World War II, a neighborhood that maintained its white ethnicity even when surrounding communities changed to black population. Organizer trainees, especially those who were black or Hispanic, had considerable difficulty with this.

I personally found Alinsky's history lessons valuable. He was teaching what he believed to be the universal principles of community organizing by using an exemplary model from his past experience and trying to put his trainees back into that situation. History perhaps acted as an antidote to the trainees' sense that only their present organizing activity had meaning, that the past was irrelevant. (A competent clinical sociologist learns how to relate the past to the present program.) The project leaders were also totally caught up in their immediate efforts to organize the poor in Syracuse. They began to feel that they knew more than Alinsky, who soon found himself with time on his hands during his consultation trips to Syracuse. I was asked to spend time with him, probably to keep him out of the way of the leadership of the project, who were busy devising strategies that seemed to fail quickly. I ended up having two afternoons of private consultation with Alinsky. I do not remember a great deal about these conversations, but one thing stands out: as we talked, his demeanor changed from his usual public presentation of an egocentric curmudgeon to that of a more sensitive, caring person. After our meetings, however, his public style quickly returned. While my encounters with him were short and probably not very important to him, they remained with me.

If one examines the public biography of Saul Alinsky, he emerges as a criminologist and then as a community organizer before the Second World
War. He then reemerges about 1950 with organizing attempts on the West Coast where Fred Ross was his major organizer (he discovered Cesar Chavez), and in the Midwest, especially Chicago. During World War II Alinsky stated that he was a special troubleshooter for President Roosevelt, trying to handle labor disputes at factories that were critical to the war effort. He also spent time with his wife, who was ill and eventually died. He went back to organizing after the war ended.

We do not have to accept all of Alinsky's goals and values in order to see him as a clinical sociologist. The nature of his impact on community organizing is still being debated. The two articles printed here show a practitioner at work — sociological theory and concepts were essential to his approach to social change.
Current Contributions

Overcoming Barriers to Clinical Sociology

Alfred McClung Lee

ABSTRACT

The search for bridges between theory and practice is related to such terms as sociatrist, institutional psychiatrist, societal technician, and clinical sociologist. The need to inject clinical sociological findings into the work of the public relations counselor, personnel director, management specialist, labor relations consultant, political manager, opinion analyst, and social worker is outlined. Special attention is given to (1) societal and especially middle-class professional cultural obstacles to the development of realistic clinical sociological research, theory, and practice; (2) disciplinary barriers against the clinical approach built into much sociology; and (3) historical trends that now appear to be favoring the formal emergence and recognition of clinical sociology.

The Seeds of Clinical Sociology

My experiences in becoming involved in clinical sociology are similar to those of many others. As Roger Straus points out, “the recent reemergence of clinical sociology . . . was not planned, it was not thought out in advance, not coordinated by any means whatsoever, nor were there any particular schools, groups, cliques, or regions responsible for its sudden reappearance on the scene” (Straus 1979:479).

My own gradual initiation into what we now call “clinical sociology” was from a background of literature, practical politics, newspaper journalism, and formal sociology. At the outset I was intrigued by four possible professional labels for what I was doing and wanted to do: public relations specialist or consultant, societal technician, sociatrist, and institutional psychiatrist.

A seminar in advanced sociological theory held at the University of Pittsburgh in the early 1930s led me to combine my background experiences with sociology into what I later would call clinical sociology. The seminar was conducted by Frederick F. Stephan, who was later at Cornell and then Princeton and was long an officer of the American Statistical Association. He was also
just taking over as part-time director of the local Bureau of Social Research, a nonprofit community enterprise. Stephan brought to the seminar a competent background in formal sociological theory of a traditional and conventional sort, and a love for its abstractions and for the virtues of statistical methodology. His work for the Bureau was just starting to give him some clinical experience.

I had been in newspaper work and was secretary of the Better Traffic Committee of the city government and press relations officer for the Helping Hand Hotel for Homeless Men, a community effort to assist some 1,500 victims of the Depression.

I was also a candidate for the M.A. in sociology. During my undergraduate years, I had taken one course in sociology, but my work then in literature and mathematics was a good substitute.

I tried to relate the theories of our seminar to my efforts on behalf of miserable men and to my work attempting to reduce traffic accidents and traffic congestion. Stephan and I became good friends, and together we tried to face facts about the crude worlds of the unemployed, the city government, and the business community. Traditional sociological theories supported the status quo and called for cosmetic changes, but they did little to help to understand the brutalities and creativities of the worlds with which we were trying to deal. The brutalities were near and actual starvation, business conspiracies and blindness, and political gangsterism and collusion with the underworld and with business. The creativities were in the form of dedicated business and political leaders who tried against great odds to contribute constructively to human welfare.

Stephan and I both believed that there are bridges between sociological studies and practical interventions and other social actions, between a theoretical and an applied sociology. My association with him introduced me to a number of social theorists; it helped to launch me on a long and continuing search for ways to bring useful sociological findings into practice and to modify sociological perspectives in the light of clinical experiences. I rejected the pretentious labels of "sociatrist" and "institutional psychiatrist." I had introduced "sociatry" in 1940 to designate "the clinical study of groups and of society" and therapeutic work with them, and I had written to try to give "institutional psychiatry" a similar meaning. Much closer to a usable label, it occurred to me, was "societal technician," which I defined in 1943 as a specialist in analyzing institutional structure, function, and change, in diagnosing maladjustments, in facilitating adjustments, in estimating the wise role for a client in a prevailing situation, and in predicting future possibilities. His (or her) facilitation of societal adjustments necessitates as adequate as possible a knowledge of
the techniques of social and cultural manipulation as well as of the trend and range of permissible experimentation in the pertinent social situation.

As public relations counselor, management specialist, labor relations consultant, personnel director, political manager, sentiment analyst, or whatever, the societal technician avails himself (or herself) — to the extent of his (or her) time, curiosity, and ability — of what has been learned about society by social scientists as this knowledge has a bearing on the solution of practical problems. The experiences of certain societal technicians — Abd-al-Rahman ibn-Khaldûn, Niccolo Machiavelli, Lincoln Steffens, Ivy L. Lee, and George Gallup, for examples — have also added in their turn to the knowledge of social scientists. Such contributions of "clinical findings" are usually rendered obscure by discretion, but they are occasionally reported by technicians in moments of candor or after their retirement, and are now more often made available by governmental investigating committees. (Lee 1943:273; cf. 1966: chapt. 22)

That definition of societal technician sounds a lot like a definition for "sociology, clinical" that I published about the same time (Fairchild, ed. 1944:303). Clinical sociology is the more inclusive term. As an alternative, a macroclinical sociologist might be called a societal technician.

As I continued to concern myself with the orientation to applied sociology that I called "clinical," I came to see more and more clearly the barriers confronted by those who would employ such an approach. Viewed in the broad perspective of the evolving humanities and sciences in European-American society, the cultishness of much sociological thinking, writing, and organizational work is apparent. This cultishness, plus the bourgeois professional orientation of so many social scientists, has made it difficult to develop clinical sociology and has tended to isolate it from such sister fields as public relations, market research, community organization, and social work. Let us look at (1) societal and especially middle-class professional cultural obstacles to the development of clinical sociological research, theory, and practice; (2) disciplinary barriers against the clinical approach built into much sociology; and (3) historical trends that now appear to be favoring the formal reemergence and recognition of clinical sociology.

In developing these three points, I take into consideration the divergence in the resistance to micro- and macroclinical sociology as well as the differences in the emphases and organizational relationships of the two levels of clinical sociological work (Lee 1979). The micro approach appears deviant to some and faces resistance not only within sociology but also from the other
disciplines with which its practitioners seek to work. It arouses old fears of being identified with social case workers or of being swallowed by social psychology. On the other hand, the macro approach brings on the anxiety of being called a "do-gooder," a "reformer," a "fixer for the establishment," a "manipulator," or even a "Marxist" or a "red."

Cultural Obstacles to Clinical Sociology

The history of the social sciences contains a number of ambiguities, but one is particularly relevant to our problem. On the one hand, as Robert S. Lynd (1939:115-16) notes, "the social sciences have developed as instruments for coping with areas of strain and uncertainty in culture." On the other hand, as he adds, "in a culture patterned to oppose changes in fundamental rituals and beliefs, social scientists manifest some hesitation as regards forthright teaching and research on problems explicitly concerned with fundamental change." He illustrates this point "by the relatively short shrift which Karl Marx receives from the social scientists (as of 1939) in our universities." Many professors behave this way because "they cannot afford to commit hara-kiri."

The domestic and international social conflicts of recent decades have modified the academic situation somewhat. Domesticated versions of Marx’s theories are now more commonly discussed. However, "establishment" or "safe" sociology still reflects the traditional notions of the role of the middle-class professional in our society. These notions include moderation, compromise, respect for and service to the existing power structure, curiosity about but not involvement in lower-class problems, a focus on symptoms rather than on causes of social problems, and faith in cosmetic modifications as adaptations of society to changed conditions (see Freeman et al. 1983). In the current period we see these notions becoming even more restrictive through their reinforcement by grant-making and contract-signing authorities.

In contrast to such middle-class notions, to be an effective clinical sociologist, even on the micro level, one has to be able to perceive as accurately as possible the social controls, manipulations, exploitations, and opportunities in a given social situation, and has to be willing to intervene in a constructive manner on behalf of one’s client. On a macro level interventions frequently have to be along nontraditional lines to be effective. They are not necessarily reprehensible societally or in terms of professional mores, especially when the interventions prove to be workable, but they are often speculative in terms of traditional standards.

Extreme but useful examples of nontraditional procedures for trying to change American society are provided by some leaders who would not label themselves as clinical sociologists — for example, such labor leaders as John L. Lewis of the United Mine Workers’ Union and the Congress of Industrial
Organizations and Walter Reuther of the United Automobile Workers’ Union (Galenson 1960) and such opponents of war as A. J. Muste (Muste 1947); J. A. Robinson (1981) and Dorothy Day (Day 1973; Piehl 1982). Each contributed to changing American society, but it is instructive to ask how each might have been made more effective by the work of clinical sociologists.

Individual life histories reveal how traditional professional group moral facades and mores preventing constructive work can either be dodged or modified. It is notable how often lower-class or upper-class backgrounds or deviant middle-class families produce the kind of professionals that are especially fitted to do clinical sociological work. Many sociologists with clinical inclinations were aided in their objectivity, as was W. G. Sumner, by their lower-class families. Many others were similarly influenced by their minority ethnic backgrounds. Also helpful have been such de-classing experiences as investigative journalism, well illustrated by such persons as Robert E. Park, Robert S. Lynd, and C. Wright Mills.

Typically, in our society a client for micro- or macro-level services develops critical problems before a clinical sociologist — by whatever label — is asked for help. Preventive measures are potentially valuable and occasionally are used even when a client has not been through a crisis, but this is not common. An organization’s or an individual’s first recourse to clinical sociological specialists is usually in a near-panic situation. Then the client is ready to go beyond the palliatives or organizational routines of servile, policy-oriented staff members.

**Disciplinary Barriers to Clinical Sociology**

The struggle during the past century to make sociology recognized and supported as a distinct, scientific, and useful discipline has been and continues to be a tough and abrasive conflict. Sociology’s promoters and apologists identified their calling with science and statistics rather than with religious dogoodism, doctrinaire radicalism, and journalistic muckraking. They built terminological and methodological defenses against possible encroachments by other social scientists. This all meant being “positive” and noncontroversial in a social sense. They wanted to avoid being political even at the price of lacking any particular social significance (Lee 1978; 1981). Thus Suzanne Powers (1979:554) is able to state quite accurately that clinical sociology is “not a new concept,” but “it is only not new to a very few sociologists; most sociologists and professionals outside sociology remain unaware of this possible application of our discipline” (see Glass 1979).

The struggle to get recognition for work in clinical sociology vividly reminds me of my experience when I gave my first paper in 1939 before a session of the American Sociological Society. No sooner had I presented the
paper, entitled "Theoretical Orientation of the Public Relations Counsel," than Edward A. Ross, then recently retired from the University of Wisconsin, sprang to his feet and denounced me for presenting such a paper. He did not attack the accuracy of what I had discussed. As I recall, I had even referred favorably to his famous *Social Control* (1901). He did not want public relations practitioners to be taken seriously as having contributions to make from their experiences to our knowledge of social technology and of society. It has to be remembered that Ross had been fired from Stanford University because he expressed concern about abuses by the Stanford family's commercial interests. He mistook my analytical interest in public relations practitioners and, thus, in a kind of clinical sociology; he saw it as, in effect, praise for his old enemy. Ross's attitude was extreme, but it resembles that of many other sociologists to whom actual participation in social action is too difficult to try to understand.

Some policy analysts oversimplify and speak far too loosely of there being two types of intellectuals. These are the technocrats, who are suitably policy-oriented and thus are assumed to be useful only as routine servants of the powerful in tasks related to social management and manipulation; and the autonomous professionals, who are oriented to socially acceptable ethics. The latter are not always trusted by the powerful even when their values appear to be satisfactory. They include persons independent and curious-minded enough to be able to suggest and try to implement novel social interventions. It has been the sociologists of the latter sort who have tried and been able to develop, under one label or another, what we are now able to put together as clinical sociology.

I have compared the autonomous public relations practitioner with the experienced psychiatrist, the two operating in different but related fields of competence. In contrast, the servile technocrat in either field humors the patient or client in his or her maladjustments rather than helping to find a more workable and constructive social role (Lee 1943:274-75).

**Historical Trends Now Favoring Clinical Sociology**

The ivory tower, the library stacks, and the data processing machines have for years held a great many sociologists away from actual involvement in social affairs or even first-hand observation of them. These institutions are all useful, and I would not belittle them, but many developments have helped to pry more and more sociologists away from an exclusive obsession with them. Through the years industrial and racial unrest, wars, crime, family problems, slums, health and other problems have demanded and received first-hand attention from many sociologists. Veterans returning from the wars helped to educate their teachers. Part-time students, employed in a wide range of ac-
tivities, brought their participant observations into classroom discussions. The drawing of sociologists into consulting and applied research relationships has been influential.

The proliferation of specialties more or less within sociology indicates the growing tendency of sociologists to bridge gaps between theoretical work and practical problem solving. I have in mind developments in social work, family life, ageism, sexism, criminology, propaganda analysis, international struggles and manipulations, interethnic tensions and inequalities, and mental health. Sociologists have gradually been drawn into many social issues and conflicts and they have found constructive roles based on that specialized knowledge.

The fragmentation of sociological organization has helped these tendencies. Especially useful have been the Society for the Study of Social Problems, divisions within the American Sociological Association such as those devoted to Marxism and to sociological practice, a variety of psychotherapeutic bodies, and such interdisciplinary organizations as those of social workers, opinion researchers, public relations counselors, and mass communication specialists.

A significant step within the sociological discipline was the formation in 1950-51 of the Society for the Study of Social Problems (Lee 1973:134-38; Lee and Lee 1976). It has attracted both people employed outside the academies and those from a range of academic specialties. Two other significant steps were the establishment of the Association for Humanist Society (AHS) in 1975-76 and of the Clinical Sociology Association (CSA) shortly thereafter. The AHS is needed to reaffirm and strengthen the roles of values and intellectual autonomy among sociologists, of values committed to social welfare rather than merely to private goals. The CSA furthers this development, supplementing rather than subsuming the roles of other associations. Its members boldly enter the world of public affairs.

These three organizations can represent for individuals three steps in personal professional development: (1) more direct involvement in social problems; (2) development of an interest in coping with social problems in a humanistically constructive fashion; and (3) actually entering into diagnostic and prescriptive work on behalf of specific clients.

Now that human society faces the greatest threats to its persistence that it ever has, threats that are bringing crisis conditions to individuals and organizations of all sorts, all possible technologies are being assessed as ways of coping. Unfortunately, these ways are sometimes irrational, mystical, or delusory; some are misleadingly manipulative and some, finally, have a chance of being helpful and socially constructive.

This growing crisis in global affairs represents a tremendous challenge to clinical sociologists as well as to other professionals. Let us hope that we shall
have increasing opportunities to demonstrate and improve the usefulness of our diagnoses, therapies, and strategies and that they will thereby come to be more and more widely employed.

NOTES

1. An earlier version of this paper was printed as “The Long Struggle to Make Sociology Useful” in Public Relations 38, no. 7:8-11. It was also presented to the plenary session of the First Annual CSA Cooperative Training Conference, Stella Niagara, New York, in August 1981. Helpful comments and suggestions on an earlier draft of this paper were made by Janet Mancini Billson, Arthur B. Shostak, and — as always — Elizabeth Briant Lee.

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Straus, Roger.  
Changing the Definition of the Situation: Toward a Theory of Sociological Intervention

Roger A. Straus

ABSTRACT

The sociological intervention is identified as (1) directed at the operational definition of the situation and (2) taking into account the multiple, interacting layers of social participation framing human predicaments and their resolution. These are further differentiated, employing case examples, in terms of mode of attack — direct, indirect, or cooperative — and level of social context at which the intervention is directed — the personal, group, organizational, or social world being described here as "quantum" levels of interest. While others may conduct such interventions, the sociological intervention is characterized as the special domain of the clinical sociologist.

Sociology, unlike medicine or psychology, has never sought to maintain the strong disciplinary boundaries typical of "a specialty." Rather, in its historical posture of a generalizing social science encompassing the subject areas of the other social/behavioral disciplines, sociology has freely disseminated to others its findings, concepts, and methods while maintaining only a marginal interest in "applied" work. Consequently, while our subterranean tradition of clinical sociology reemerged around 1978, we have found it difficult to specify exactly the special contribution or expertise of the sociological practitioner.

To limit the domain of clinical sociology to what self-identified clinical sociologists do or have done would, if anything, be counterproductive, as Lee (1973) and others have argued. As one who has been intimately concerned with the problem of defining our field for some years now, I believe we are ready to move beyond presentation of the variety of roles enacted by clinical sociologists (cf. Straus 1979a) to tease out the underlying logic of approach characterizing the specifically sociological intervention.

In this paper, then, I shall state my findings that, on the basis of analyzing the published and unpublished literature of the field, the sociological interven-
tion may be characterized as (1) directed at the operational definition of the situation, in such a way as to (2) take into account the multiple, interacting layers of social participation framing human problems and predicaments and their resolution.

Contemporary practitioners of clinical sociology almost universally characterize themselves as *humanists* in Lee's sense of the term (1973). While extrinsic to my general definition, this value orientation is useful when differentiating clinical sociological practice from more conventional "applied social science" (Lee 1978). Our interventions are aimed at empowering clients instead of simply adjusting them to the "realities of life." Rather than adopt the expert's role of prescribing a better or more appropriate reality for the client, we strive to minimize interference with the client's worlds and values; rather than serve the needs of "the system," we attempt to serve the needs of the human beings comprising the social unit or system in question (Straus 1982).

**Operational Definition of the Situation**

Translation of social theory, concept, and method into practice necessitates both theoretical eclecticism and some reworking of our usual formulations. Thomas's "definition of the situation" (1931) is usually understood phenomenologically to mean that whatever a person or group believes or accepts to be so is real in its consequences. While it is important to deal with socially constructed realities at this intrapersonal level, since they form the basis upon which conduct will be constructed by human actors (Blumer 1969), redefinition of internalized meanings and cognitive maps is mainly a concern of sociological counselors working with individuals and primary groups (Straus 1982). Most sociological interventions are more concerned with the manifestation of these "realities" in patterns of conduct and joint conduct being enacted by the individuals, groups, and/or systems under scrutiny.

Thomas's statement of the principle was somewhat ambiguous about the nature of the definition of the situation, but was clear about the dialectical relationship between the individual's definition and the definition of the situation *presented* by others. These concepts are neatly summarized in Sarbin's (1976) characterization of the dramaturgical perspective holding that

actors not only respond to situations, but also mold and create them. . . . The interactions of participants define the situation. The units of interest are not individuals, not organisms, not assemblages of traits, but interacting persons in identifiable contexts.
It is the pattern of these interactions that corresponds to the operational definition of the situation and that is the target of sociological intervention.

**Levels of Social Context**

Both the original statement of definition of the situation and its dramaturgical operationalization are clear about the situated nature of conduct. They are not so clear about the complex and many-tiered nature of social ecologies and about how human behavior is situationally organized with respect to a subject’s concrete location within that total social context. However, clinical sociologists are sensitive to the implications of how “social systems” at every level influence ongoing action. This sensitivity is then translated into practical actions designed to mitigate negative interlevel influences and/or to use these dynamics strategically to guide and stabilize positive change. As Freedman and Rosenfeld have put it (1983), the clinical sociologist uses a paradigm of “the integration of levels of focus” incorporating both “macro” and “micro” viewpoints. Thus, the characteristic sociological intervention combines multiple foci: “the group member, the groups to which the person belongs or desires to belong or not belong, organizations, committees, subcultures, culture, and society.”

In this paper it is necessary to adopt a typology of the various levels of social context; clearly, how one slices the social continuum represents a pragmatic choice relative to one’s purpose. For example, Parsons (1951) selected a scheme appropriate to his theory of social action, while Lofland (1976) utilized an entirely different model of “human systems.” As my purpose here is to describe sociological intervention generically, we will look at just four “quantum levels” of social participation: persons, groups, organizations, and worlds.

The first two of these correspond to general usage. *Persons* are social actors defining themselves in conduct; for our purposes, they *are* their acts. The routinized patterns of conduct colloquially referred to as “one’s act” are framed by (that is, organized in terms of) the culture of the worlds in which persons participate and the roles they play in the various groups in which they are involved.

Each level of social structure is viewed as the emergent pattern of routinized conduct representing a dialectical synthesis between the next “higher” and “lower” levels. *Groups*, then, would be conceptualized as persons with more or less routinized social relations or *roles*. The actual role structure of the group operationally defines that group. As groups necessarily establish at least tacit patterns of relationship with other groups, they inevitably become tied into any number of formal or informal organizations.

A special usage of *organizations* is employed here: this level of organized, identifiable intergroup relations is most often termed that of “social systems”
(Znaniecki 1934). However, since any interacting set of persons can be considered to form a "social system," and their relations can be analyzed in terms of systems theory (von Bertalanffy 1968), it seems best to employ another term for this structural level. Organizations, then, may range up through wider and wider scales of intergroup relations from "formal organizations," corporations, and associations to communities and governments. The operational definition of organizations consists of their institutions, meaning the routinized patterns of social relations often simply referred to as their "organization."

The highest level of social context in this typology is the social world. This usage is adapted and expanded from Lofland's definition: "Complexly interrelated sets of encounters, roles, groups, and organizations seen by participants as forming a larger whole are often and properly thought of as 'worlds,' as in the phrases 'the business world,' 'the academic world,' 'the sports world'" (1976:29). In the sense employed here, a world is operationally defined by its culture, primarily the nonmaterial culture of norms, values, folkways, mores, language, and technology differentiating its participants from members of other social worlds. Those who share a subculture by definition share a world; larger-scale worlds might include the entire society, the civilization of which it is a part, and, possibly, Spaceship Earth itself.

The Sociological Intervention

If we identify the operational definition with the target of intervention, this scheme generates the following taxonomy of sociological intervention:

<table>
<thead>
<tr>
<th>Level of Participation</th>
<th>Target of Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons</td>
<td>Conduct</td>
</tr>
<tr>
<td>Groups</td>
<td>Role Structure</td>
</tr>
<tr>
<td>Organizations</td>
<td>Institutions</td>
</tr>
<tr>
<td>Worlds</td>
<td>Culture</td>
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The intervention itself will, in one way or another, involve a strategy of redefining the situation. At the personal level, for example, sociological counseling might involve reconstruction of the client's assumptive realities and/or social-behavioral tactics specifically designed to change his or her conduct in everyday life (Straus 1979b). Unlike more conventional "psychological" or "psychosocial" counseling, only minimal attention would be placed upon intrapsychic constructs such as defense mechanisms or personality traits. On the other hand, integration of levels of focus leads the sociologist to approach a person's difficulties at this personal level as social problems intimately tied to cultural and subcultural factors, location in history
and society, reference groups, family dynamics, and the social construction of reality. Straus (1979b) has shown how, for example, obesity can be managed through a specifically sociological intervention.

**Modes of Intervention**

Interventions may be organized in terms of three different modes: the direct, indirect, and cooperative. These represent different strategies for attacking a problem. In real life, interventions generally combine one or more modes, but it remains valuable to consider them as ideal types when thinking about and planning change projects.

By “direct mode” I refer to the commonsensical approach of attacking a problem head-on. One might assess a troubled organization, devise a strategy of intervention, and then guide management in implementing the suggested changes. Since this requires the change agent to take the role of expert or “doctor,” it tends to conflict with humanist values and is therefore more typical of the social engineering approach than sociological intervention. On the other hand, while the direct mode can provoke resistance and socialize clients to rely upon external authority and “expert” guidance, it remains an invaluable tool in the sociologist’s kitbag. In fact, it is often expedient or even necessary to take an initially authoritarian role prior to weaning the client to a position of self-management (Straus 1977).

Indirect interventions enable one to avoid problems of resistance and dependency by employing tactics of indirection and/or indirect attack. The former was pioneered by noted hypnotherapist Milton V. Erickson (1980), who developed the strategy of “indirect suggestion.” The approach has been popularized in consulting circles as “neurolinguistic programming” and has been adapted to social science-based interventions by those affiliated with the Mental Research Institute in Palo Alto (Watzlawick, Weakland, and Fisch 1967). In family therapy, for example, indirect tactics might involve getting family members to cooperate with the identified problem behavior of a child, so as to get the parents to stop doing whatever they have been “doing about it,” thus blocking perpetuation of an operational definition aggravating or maintaining the family system’s problem (Fisch, Weakland, and Segal 1982).

Indirect attack is more typical of sociological intervention as practiced by clinical sociologists; the problem is resolved by directing redefinition efforts at higher and/or lower levels of social participation than that at which the identified problem lies. Cheek and Baker (1977) found that subject resistance and ethical problems associated with resocialization programs for prison inmates could be avoided by organizing “self-control training” programs for inmates. This created the latent function of reducing recidivism — the identified problem — which occurs at the organizational level of the criminal justice system.
Cooperative intervention tends to be favored in principle by clinical sociologists. In this mode the client's active participation in the change process becomes the key feature of the intervention (Lippitt and Lippitt 1978). Those who will be affected by the intervention are helped to participate in or even take primary responsibility for making decisions about and implementing the redefinition process; the role of the sociologist becomes, more than anything else, that of a facilitator (Glass 1981).

The cooperative mode may also be employed in social research to increase the study's clinical value (Leitko and Peterson 1982). Jaques's "social analysis" techniques (1982) might typify the "pure" cooperative intervention. However, in many cases (as when the situation is highly politicized and marked by considerable power differentials) the facilitator role may prove too cumbersome or simply impractical. A pure cooperative approach may also not fit the sociologist's personal strengths or style; in such cases, a mixed-mode approach will be followed.

In practice, the principle of eclecticism extends beyond theory to mode. Cases of actual sociological intervention generally display considerable theoretical eclecticism, an admixture of modal strategies, and elements of indirect approach designed to take advantage of the integration of levels of focus. In any case, the change agent can only benefit from clarifying the modes of intervention being employed.

The Personal Level

I will now flesh out these principles by discussing a variety of sociological interventions that show how these practices relate to the taxonomy. Direct intervention at the personal level, while the logical beginning point, is the most difficult to differentiate from the conventional practices of psychotherapy and counseling, but subtle — and highly significant — differences can be seen.

Even though most practitioners working at this level are associated with the microsociological paradigm of the Chicago School, they focus upon the person as member of society and not just as "an individual" with private problems. They employ a social perspective in analysis and design of intervention that focuses upon (1) the client's actual conduct in everyday life; (2) the internalized sociocultural realities that frame and organize that conduct; and (3) the relationship between these realities, the person's conduct, and his or her situation in terms of the various levels of social context (Powers 1979a, b; Strauss 1979b). Sociological interventions, whether direct or indirect, may often take clearly social forms, as in directing clients to appropriate community support networks to reinforce their definitions of the situation, or to peer self-help groups to help them reconstruct their realities outside of a therapy framework (Glassner and Freedman 1979; Strauss 1982).
Indirect approaches more clearly illustrate the special features of a sociological approach at this level. Coombs (1980) describes a drug and alcohol abuse prevention program offering a dramatic alternative to conventional asocial models which seek to scare youths away from experimentation or to treat identified users on the presumption that only sick, deviant, or deficient personalities become abusers. His approach is aimed at individuals who are in a marginal position and are likely to adopt substance-abusing identities—generally those of junior-high-school age. Coombs intervenes by working with the family groups of identified marginal youth so as to enhance family solidarity, keep the family as the youth's primary reference group (rather than drug-abusing peers), and remedy deficits in family skills such as communication, doing things together, or working as a group. Thus, the goal of defining the subject's conduct in a prosocial direction is accomplished indirectly, through what Coombs calls "family strengthening." In this kind of program, the indirect attack becomes the sociologist's primary tactic. Minimal attention is given to substance abuse itself or to correcting antisocial behavior; these are dealt with through indirect intervention at the group level.

The Group Level

Interventions at the group level are primarily directed at role structure, taking into account such factors as authority relationships, consensus regarding roles and their boundaries, degree of involvement in roles, role strain or conflict, informal versus formal realities, and the degree to which the operational definition of the group facilitates or hinders attainment of its collective purposes (see Capelle 1979). A nonsocial approach at this level can certainly be found in the practice of many marital therapists or business consultants, but such an approach becomes difficult to justify given the manifestly systemic nature of the social group, in which the whole is conspicuously more than the sum of its individual parts.

A direct sociological intervention might be exemplified by William Foote Whyte's solution to a restaurant chain's problems of inefficiency, worker dissatisfaction, and high turnover. He found that there were problems in the role structure of these restaurants. Waitresses, who were women, were placed in a position of giving orders to the higher-status cooks, who were male: those of relatively lower status were giving orders to their nominal superiors, a problem compounded by a violation of gender roles then current in American culture. Whyte's solution was to resolve role strain by a simple mechanical expedient: employment of rotating metal bands with clips on them—known as "spindles"—which allowed waitresses to post their orders in systematic fashion without having to convey them verbally to the male cooks. The changes incurred by this intervention were so dramatic that something of the sort has
become standard throughout the industry. Note how this intervention related the role structure of the group to the broader norms governing conduct in the general society.

Cooperative intervention at this level is illustrated by Kleymeyer's organization of the "Program for Humanization of Health Care in the University Hospital" at Cali, Colombia (1979). The sociologist was initially recruited as part of a quantitatively oriented research team investigating the causes behind disuse of outpatient services. He trained some of their native interviewers to conduct field observations of service delivery in their spare time. Evaluating their reports, he found that the public considered services dehumanizing, anxiety provoking, and alienating. He was then invited by the hospital's leadership to devise strategies to mitigate this situation.

Recognizing the potential problems for an outsider in trying to impose change from above, Kleymeyer chose to adopt the role of costrategist, instigator, and facilitator of change. He allowed the politically savvy head of human relations for the hospital to do the actual moving and shaking. In selecting, designing, evaluating, and fine tuning innovations, he drew upon key hospital personnel, client interviews, professionals on the scene, and workers' forums that had been developed early in the change project, so that intervention was permitted to take a locally generated and self-directing course. These innovations included courses in human relations and first aid for hospital staff, workers' forums, creation of an in-house position of "patients' representative," material incentives for humane and competent treatment, and other changes involving training personnel in necessary role skills, redefining existing roles, or developing new patterns of social relations. By this strategy, Kleymeyer sought to establish a permanent, self-perpetuating, participatory institutional structure that would outlive his contractually limited tenure in the hospital setting.

The Organizational Level

Strategies at the organizational level represent, for the most part, an elaboration of group-level tactics. However, redefinition is primarily aimed at the institutionalized patterns of relations between groups rather than role relations within the group.

Direct tactics, although often too straightforward, can be effective. For example, Trist (1981) describes an intervention in the Norwegian shipping industry. Onboard facilities were redesigned to promote a sense of community among the various crew and officer groups who must live together under isolated conditions twenty-four hours a day over extended periods of time. Redefinition of the shipboard environment to facilitate this new pattern of social relations included creating common recreation rooms and dining halls
where all ranks and ratings could mingle (normally each group ate and socialized independently in status-graded facilities); integrating deck and engine room crew; and reducing status differentials between officers and crew.

An example of indirect approach has been described by Freedman and Rosenfeld (1983), who were invited by the New Jersey Division of Mental Health and Hospitals to assist in the implementation of mandated changes aimed at humanization of services and expediting the release of clients to their local communities. Their initial assignment involved implementing a new standardized record-keeping system for the six state hospitals. It soon became obvious, however, that there was no real agreement, even among leadership, as to precisely what was desired or how to go about doing it. Furthermore, true implementation of the new policies would require significant redefinition of roles, relations between various groups within the hospital system, and even meanings of basic terms such as case management or team approach.

To forestall conflict and yet implement these major redefinitions, they devised an indirect strategy centered on the introduction of the new form. As is usual in such organizations, a training program was instituted concerning the use of this form. In this case, however, both the design of the form itself and that of the training program were deliberately organized to have the latent function of redefining roles, institutions, and the culture of this system. Thus, an ostensibly limited and innocuous innovation — a new record-keeping technology — was used as an indirect strategy for organization-scale change.

Cooperative strategies at this level have long been a staple of sociological practice (Shostak 1966; Jaques 1982). However, this kind of approach has only recently been extended to areas such as the management of social impacts from government or industrial development projects. “Social Impact Management” (Preister and Kent 1984), for example, brings members of communities to be affected by large-scale projects into the process of negotiating and working out a mutually acceptable plan to deal with issues and manage potential impacts that will be compatible with or actually benefit those affected by the proposed development. Special care is taken to identify and involve community networks and to mitigate impacts at all levels of the local context so as to maintain the integrity of community life and organization.

The World Level

At the highest scale we are considering, that of social worlds, sociological interventions can take even more complex forms. For Lee (1979) the direct approach at this most macrosocial level is identified with humanistically framed, change-oriented research; he views the sociological clinician as seeking to understand through first-hand materials how socially organized situations actually function and how they can be influenced; he then suggests practical
strategies for modifying or coping with problematic social realities, trends, and developments. His work has included the study of propaganda in our society with the goal of sensitizing the broad public to the problem and generating the necessary consciousness to defend them from this kind of manipulation. Significantly, his major work on the subject was published in 1952, during the rise of the cold war mentality and rapid expansion of the advertising profession. Clearly his intent was to generate cultural defenses against the manipulation of society by elites.

California’s “Friends Can Be Good Medicine” campaign is a good example of a world-scale intervention combining both indirect and cooperative modes. By devoting a small fraction of its annual mental health budget to this preventive intervention, the state hoped to combat rising demands upon its health and mental health systems. Its strategy was based upon the copious recent literature documenting the inverse relationship between involvement in primary groups and the rates of incidence of mental and physical health problems (see Hunter 1982 for a summary of the literature). Its plan was to bring about a change in culture by raising the general consciousness regarding the direct personal benefits of developing and maintaining social support networks (Hunter 1982). This strategy therefore incorporated both indirect and direct attack.

Delivery utilized a cooperative approach. The consulting firm hired for the campaign developed printed training and information materials, audiovisual training films, and a series of radio and television spots stressing the message that “friends can be good medicine.” Ten paid coordinators then recruited volunteer regional coordinators (I was one) from county agencies and networks. After a trainers’ workshop, these volunteers then recruited and trained community-level leaders from education, the churches, business, government, and other local networks to deliver workshops and set up local events during the month of June 1982. The entire state was to be saturated by community-based consciousness-raising events supported by a media blitz — all at minimal cost to the state. This was the first statewide mental health prevention program to date.

This campaign, designed exclusively by psychologists and “applied behavioral scientists,” illustrates as well some of the pitfalls stemming from exclusion of sociologists from organizing and implementing sociological intervention. In this case, the “cultural approach” historically associated with clinical sociology (Wirth 1931) would have had dramatic impact. Instead, the beautifully designed and printed workbooks stressed the interests of “hip” humanistic psychologists — alternative life styles, consciousness-raising groups, and new games. They were also written so as to require a high level of literacy and intellectual orientation. In effect, they might have been designed to be rejected by rural, working-class, and poor people; businessmen; and con-
servatives: most of the population, in fact. The materials also evidenced no awareness on the part of their producers of the long-term macrosocial changes underlying the disruption of traditional support networks and primary group structures, leaving the impression that alienation from significant others was a purely individual matter, entirely correctable by personal action.

**Between-Levels Intervention**

It is important to point out that the model presented here can also be used to typify interventions targeted at interpersonal, intergroup, interorganization, and interworld problems. In essence, between-level interventions operate at the next level upscale. An interpersonal problem would be treated as a blockage, misalignment, or other difficulty at the group level. In solving such a problem, one helps those concerned to work out joint definitions of the situation by clarifying their respective roles and statuses. Intervention might involve improving communications, resolving contradictions in participants' definitions of the situation, or creating entirely new, mutually acceptable definitions, including recognition of their de facto status as a group. Except that our model typifies interworld collectivities simply as higher-scale social worlds, the same logic is followed at the higher levels of between-levels intervention.

**Conclusion**

It has been my concern in this paper to tease out the generic logic and structure of sociological interventions. By presenting this within a taxonomic framework, I have sought to sensitize the practitioner to the special features of the sociological approach and also to move a discussion of the substance of clinical sociology up to a more concrete and hence manageable level.

Implicit in the foregoing is the premise that many or most problems encountered in social life, from the personal to the societal levels, can best be understood and dealt with as social problems. They cry out for sociological intervention, which is defined here as reconstructing the operational definition of the situation with reference to the multiple, interacting layers of social context framing any particular case.

Clinical sociology is not identical with sociological intervention, for both sociologists and nonsociologists can and do engage in this form of work. However, it becomes apparent that the clinical sociologist is best qualified to practice sociological intervention because the approach lies squarely in the domain carved out by sociological training, sociological tradition, and the special sensitivities inculcated only by immersion in a specifically sociological perspective.
NOTES

1. Those specializing in sociological counseling or therapy at the personal level might wish to discriminate a still more micro-scale intervention: the intrapersonal. Here, the client's phenomenological definitions of the situation as manifested in cognitive, psychomotor, and/or psychosomatic self-interactions become the target for change (Straus 1983). However, these are still analyzed within the context of a social problem framed by culture and group participation and managed similarly to intervention at the molar "personal" level.

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The Clinical Sociologist as Family Therapist: Utilizing the Strategic Communication Approach

Gary M. Voelkl and Kenneth Colburn, Jr.

ABSTRACT

This article acquaints the clinical sociologist with the sociodynamic model underlying the family therapy approach associated with the "Palo Alto" group and referred to here as the strategic communication approach to family therapy (SCAFT). It establishes the relevance and compatibility of this form of therapy to sociological theory and practice. The basic features of the field of family therapy are described through a selected treatment of several prominent contributors. The authors illustrate the utility of SCAFT for the clinical sociologist by drawing on case studies from their private practice. In the conclusion they emphasize the continuity between SCAFT and sociological principles.

Introduction

As Hansen and L'Abate have observed, "One of the most unfortunate gaps for the field of family therapy is its separation from the field of family theory as found in sociology" (1982:296). This paper attempts to close the gap between family therapy and sociology by drawing the strategic communication approach to family therapy (SCAFT) to the attention of clinical sociologists.

In the sociodynamic perspective, problems are interpreted as being created by the social organization of human relationships. One may learn about that organization by attending to sequences of interaction as they occur among group members. Moreover, by observing the sequences of communication within a group, a therapist becomes acquainted with the distribution of influence within that group. A consideration of the element of power in a social system and the members' attempts to secure it is useful to one operating from a sociodynamic model. In this paper the sociodynamic perspective is related to family therapy, and implications of both for clinical sociology are explored.
A Historical Overview of Family Therapy

Any attempt to summarize or define the field of family therapy must, at present, be understood as necessarily tentative and incomplete because of the field's disciplinary and theoretical diversity, its relatively recent and intense growth, and its developmental character. Our attempt to provide a selected overview of the field represents an oversimplification and cannot be substituted for more extensive reading (see Beels and Ferber 1969; Sporakowski and Mills 1969; Olson 1970; Hansen and L'Abate 1982; Horne and Ohlsen 1982).

The mid-1950s is recognized by most authors (e.g., Olson 1970; Hansen and L'Abate 1982) as the starting point of the modern family therapy movement. While, strictly speaking, family therapy can be traced back to the child guidance clinics of the 1920s, the profession of psychiatry gained early control over the organization and methods of treatment employed in these clinics, resulting in the application of traditional personality or intrapersonal models of human conduct to troubled families. Traditionally, the psychiatrist saw the child, the psychologist conducted the diagnostic testing, and the social worker saw the mother — more often than not the father was left out of the treatment plan (Olson 1970:504). In this traditional clinical setting, the key feature of modern family therapy is absent — namely, the shifting of the theoretical and therapeutic perspective from the individual to the relationship between self and others comprising the family system. Clearly it is relationship-oriented theory and procedures, focusing on the family as a social interaction system, that distinguishes family therapy from the traditional psychotherapeutic emphasis on the individual personality and biography.

Nathan W. Ackerman (1958; 1966; 1970) is perhaps the earliest and most widely known proponent of family therapy. Although trained as a psychoanalyst and child psychiatrist, Ackerman was influenced by social psychology and its emphasis upon understanding the individual in terms of the social situation. He published a paper on the family as a social emotional unit in 1937, began experimenting with family therapy treatment in the late 1940s, and became the director of the first Family Mental Health Clinic in New York City in 1957. In 1962 he joined Don Jackson to found the first journal of family therapy, *Family Process*.

Ackerman occupies a special place in the field of family therapy; although he did not completely abandon the traditional psychotherapeutic viewpoint of his training, he realized the need for new thinking and approaches to the individual which took into account his or her family situation and social involvement with other family members. Here he borrowed the concept of social role from the work of Kurt Lewin, which permitted him to identify reciprocal and complementary roles among family members. Two notions
beyond that of social role are important to Ackerman. The first is that of family identity, the way each family group defines its purposes and goals, a definition that is reflected and expressed in some way by each family member; the second is the notion of family stability or equilibrium. Believing that there is no essential difference between a healthy family and a sick family, Ackerman thought that problems resulted from a family's inability to maintain the necessary flexibility or responsiveness among its various role relationships to permit the optimum adaptation for the family system as a whole. The aim of therapy is to help a family achieve this stability by working with members in such a way as to make greater role adaptation possible. This would increase the family's ability to resolve conflict in positive ways. Ackerman emphasized that the clinician must see and work with all members of the family during the early and middle phases of therapy, to create opportunities for both firsthand observation and direct intervention in the family interaction. It is the addition of this latter focus on the family as the unit of treatment that qualifies Ackerman's work as family therapy.

Like Ackerman, Murray Bowen (1961; 1965; 1976; 1978) was medically trained in the psychoanalytic mode of therapy and found this approach in need of revision in the light of his research at the National Institute of Mental Health with families of schizophrenics. During the mid-1950s, Bowen invited families of schizophrenic patients to live in the hospital wards so they could be observed and intervened with more effectively as a family group. Although Bowen accepted the psychoanalytic account of the origins of the emotional conflict experienced by his patients, he did not find the therapeutic techniques of psychoanalysis to be effective in treating the more severe cases. Bowen's theory and practice emerged from his efforts to modify psychoanalysis to treat schizophrenics in their family context.

Bowen's theory centers on two main concepts: the degree of anxiety experienced by a person and the degree of integration of self. Bowen views emotional illness as rooted in the system of relationships in the family, involving interlocking triangles that reach over more than one generation. He proposes that the dyad he viewed as inherently unstable, for when anxiety arises, a third person is brought in to relieve the strain, creating an interlocking triangle. The reduction of anxiety made possible by this new triad permits the persons involved to return to their previous structure of relationships. With low anxiety it may be possible for all members of the triad to relate to one another as individuals; the ability of a person to relate as a differentiated individual within the family is a primary focus of therapy. Bowen's basic therapeutic assumption is that if individual differentiation occurs, the change thus brought about in the individual will bring about a change in the family system.

Self-differentiation for Bowen is a person's ability to separate intellectual from emotional functioning, with the more differentiated self being able to
engage in cognitive rather than emotive reasoning and behavior. Intellectual
control of one's life, experiences, and social situation is seen to make possible
greater flexibility in response to critical life situations; hence control is gained
over the anxiety which they can produce. Bowen's approach relies heavily on
the psychodynamic model stressing intrapersonal factors, even if somewhat
modified by a family systems perspective. The therapeutic focus of family
therapy for Bowen seems to remain on the level of individual treatment,
although theoretically the social relationships between family members are
stressed. The interactional or transactional patterns between family members,
involving communication, are of less concern for Bowen than for Ackerman.

The strategic communication approach to family therapy evolved during
Gregory Bateson's decade of research (1952-62) and focused on the com-
munication patterns of families with schizophrenic members in the Veterans
Administration Hospital, Palo Alto, California. Bateson's project staff in-
cluded Don D. Jackson, John Weakland, and Jay Haley. Out of this project
the now-famous double-bind theory of schizophrenia was developed (Bateson
et al. 1956). The basic idea of this theory is that schizophrenic behavior is not
simply an individual phenomenon; it is rooted in communicative patterns of
interaction between family members that both generate and sustain one
member's apparent schizophrenic conduct. In the typical double-bind situa-
tion, two contradictory messages are simultaneously given from parent(s) to
child, one direct and the other indirect. As a consequence, an adequate
response on the part of the child is impossible, which results in schizophrenic
behavior — viewed then as an adaptive response by the child to the double-
bind into which it has been placed.

In 1958 Jackson founded the Mental Research Institute (MRI) in Palo
Alto. It attracted such persons as Haley, Virginia Satir, and Paul Watzlawick.
Haley became the first editor of Family Process, which was sponsored both by
the MRI and the Family Institute of New York (directed by Ackerman).³
Under Jackson's leadership, the MRI began to study and train professionals in
conjoint family therapy — Jackson's term for treatment in which all family
members are seen together by the therapist.

Jay Haley ranks among the most innovative and dynamic, if somewhat
controversial, figures in contemporary family therapy. Much of the freshness
of Haley's approach to family therapy, rooted primarily in communication
theory, is no doubt related to the fact that he was not formally trained as a
psychoanalyst, a clinical psychologist, or a psychiatrist. Joining Jackson at the
MRI in 1962, after the Bateson project had ended, Haley continued to study
communication and learned about role theory (1978); he also became involved
in research on covert coalitions (1962), the notion that the identified patient
reflects a coalition of two persons against the patient. During this time Haley
also identified power struggles within the family as a key issue of therapy,
especially since the therapist's intervention in the family poses the prospect of his being enlisted by one or more family members as part of the coalition striving for dominance over other members. Haley emphasizes the dimension of power in all social relationships, suggesting that an essential but indirect feature of all communication involves claims and counterclaims to dominance and deferral within relationships. He defined three types of relationships: symmetrical, complementary, and metacomplementary (Haley 1963). A symmetrical relation is one in which power is roughly equivalent between self and other; more or less the same kind of behavior is engaged in and exchanged by both parties. A complementary relation is one in which self and other exchange different sorts of behavior (for example, teacher-student or therapist-client). Here a power differential exists between the two, revealing a superordinate and a subordinate status. Rules for the relationship are less likely to be determined equally by both parties. In the metacomplementary relationship, the person ostensibly with less power — the subordinate — in fact permits the other to take control, thereby creating a situation in which the subordinate actually has power over the superordinate (cf. Haley 1973).

In the mid-1960s Haley was invited to become research director at the Philadelphia Child Guidance Clinic. He established relationships with two prominent therapists who subsequently influenced his work: Salvador Minuchin, who was developing a theory of structural family therapy, and Milton Erickson, from whom Haley learned about paradoxical interventions. It is during this time that Haley's reputation and influence as a family therapist became firmly established. (Since we will explicate the SCAFT primarily through reference to Haley's work, we will defer to the following section further discussion of it. Currently, Haley is clinical professor of psychiatry at George Washington University and director of the Family Therapy Institute in Washington, D.C.).

Salvador Minuchin is an important figure in the field of modern family therapy; although he is not identified as a member of the strategic communication approach to family therapy, his influence on SCAFT and his social structural emphasis are clear. Minuchin began his career as a psychiatrist and psychoanalyst, but over time developed techniques and theories that radically departed from the intrapersonal theory and individual treatment model of those disciplines. Focusing on careful and systematic observations of family processes and structures, including communication, Minuchin has based his work solidly on the premise that the individual cannot be understood apart from his or her social context. He holds that changing the structure of the individual's social situation (for example, the family structure) will result in change for the individual.

More than any other studies by contemporary family therapists, Minuchin's work reflects the sociological perspective of structural-
functionalism in both theoretical outlook and language. Minuchin defines family structure as a set of functional imperatives that organizes the modes in which members interact. Preferential patterns of interaction constitute transactional rules concerning how, when, about what, and to whom family members should typically relate. These transactional patterns regulate family behavior and are both rooted and reflected in the subsystems of a family. At least three such subsystems can be identified: spouse, parent, and sibling. Various social skills are associated with each, and Minuchin suggests that family functioning can be determined for a particular family by the degree to which the boundaries between subsystems remain fairly clear and operational during member transactions. Boundaries between subsystems enable the family to maintain the necessary differentiation of its structure for it to function well.

The concept of boundary is probably the most basic and best-developed element of Minuchin's therapeutic model. Minuchin suggests that all families operate between two extremes of ambiguous boundaries and inflexible boundaries. The difference between a normal and pathological family is one of degree and not of kind; pathology is indicated only when a family operates solely at one end of the continuum. The condition of blurred boundaries between the subsystems of a family is referred to as enmeshment and the situation of rigid boundaries is termed disengagement. Communication is increased and intensified to a dysfunctional level in the first case and is decreased to a dysfunctional level in the second case. Both transactional patterns are seen by Minuchin as dysfunctional because the family is unable to respond well to demands for change. The restructuring of family transactional patterns and the restoration of clear but flexible boundaries between subsystems is a major focus of the therapeutic intervention for Minuchin.

Basic Assumptions of SCAFT

The strategic communication approach to family therapy is best thought of as the identification of a core set of assumptions — Kuhn's concept of a paradigm (1962) is relevant — around which somewhat different conceptual emphases and clinical techniques have evolved. There is much diversity within what we have termed SCAFT, and we do not mean to imply that all persons associated with this perspective would find themselves in agreement over many substantive and conceptual matters. Our position is that a distinctive perspective can be identified within the field of family therapy.

The first and perhaps central assumption behind SCAFT is the communication theory derived from the Bateson project. This theory involves a twofold emphasis upon (1) the nature and structure of communication and (2) the social context of communication. Communication is viewed as occurring on different levels simultaneously, giving rise to the possibility of multiple
and contradictory messages and meanings. It is also understood to be both embedded and reflected in the social relationship between two or more persons.

Thus, Haley (1976:83) has made the distinction between digital and analogic modes of communication. Digital communication is directed solely and specifically to a particular referent. In contrast, analogic communication is metaphorical; its referent is a matter other than what is specifically referred to in the discussion. Since communication reflects the social relationship in which it occurs, at least some aspect of all communication can be recognized as an analogy or metaphor about that relationship. For example, Haley (1976:32) suggests that a therapist must remain cognizant of the possibility that family members will offer indirect messages about someone other than the person directly referred to: a mother complaining that her son is too aggressive and hits her may be making an indirect statement about her husband — but it remains outside her level of awareness. A therapist must be aware of, anticipate, and be prepared to use this metaphorical aspect of communication in his or her approach to therapeutic intervention.

A second assumption underlying SCAFT is that all social relationships involve the dimension of power; it is by no means unusual for communication at least indirectly to be concerned with power and control. Power also suggests issues of hierarchy and stratification within relationships. A clinical application of this viewpoint is that at least some family or marital problems can be interpreted in terms of the inability of persons to resolve the issue of power and control.

A third assumption is that the therapist, as an expert called upon by a family, cannot fail to influence — for better or for worse — a family’s interaction system. Given recognition of this fact, the issue is not whether but rather how the clinician will make use of and accept responsibility for this influence. SCAFT emphasizes an active, interventionist approach on the part of the therapist, consisting of the explicit formulation of a strategy designed to solve a client’s presenting problem. The object of change is the social structure of relationships within the family, especially the balancing of power and the restoration of the hierarchy, for example, of parents over children. Change is brought about through a series of stages involving the use of directives from the therapist: directives are prescriptions for behavior suggested to a family that are designed to alter relationships in ways the therapist sees as more desirable for family functioning. Although clients obviously must assume responsibility for carrying out such directives, and an important task of the therapist is to motivate families to do so, the prescription of directives is the responsibility of the therapist and not the client.

Unlike traditional forms of psychotherapy, which emphasize insight and growth on the part of the client, SCAFT, through its use of directives, does not
recommend that the therapist share hypotheses concerning the cause of a family problem. Directives are designed to introduce new and alternative patterns of behavior within relationships and are intended to solve problems rather than reveal either the client's feelings about a problem or foster the client's emotional or cognitive growth. Since SCAFT views the therapist as part of a system, the aim of the therapist is to use his or her temporary leverage to induce change in the family structure and communication patterns. In this way, a change in individual feelings and attitudes should ensue. It is essential that the therapist be aware of coalitions within the family and enter these only with a definite therapeutic goal.

A final assumption of SCAFT, relating also to communication theory, is the use of paradox by the therapist. SCAFT tends to dispense with traditional psychiatric labels such as "manic depression" or "delinquency" because it is felt that such diagnostic categories are not solvable problems. Likewise, SCAFT is not concerned with discovering the etiology of a problem or a client's past; the emphasis is on determining and changing a recurring sequence of activity between two or more persons (cf. Madanes 1981:chapter 2). Change is brought about by preventing the repetition of sequences through the introduction of alternative ways for members to relate to one another. The use of paradoxical directives by the therapist is of special interest in this connection. A paradox — that is, a message that is contradictory across at least two levels of meaning — requires that the client confront his or her usual way of behaving. For example, the statement "I want you to be spontaneous and independent of anyone's wishes" involves a paradox that cannot be resolved in a perfectly satisfactory way. Whether the person attempts to resist or comply with the speaker's suggestion, some degree of contradiction will emerge.

Haley (1976:68) suggests that paradox can be used by the therapist in dealing with families that seem to be resistant to any change in family interaction patterns. In such cases, a direct approach by the therapist tends to be futile. Examples of paradoxical directives are offered by Haley (1976:72-76).

Application and Case Studies

In this section we illustrate SCAFT by offering two case studies drawn from the authors' joint private practice in clinical sociology. We have limited our examples to the consideration of a problem that is far from uncommon in our practice — namely, the therapeutic issue of restoring the balance of power in a marital relationship. We do not discuss basic therapeutic skills in this discussion since we are concerned primarily with showing how the clinical sociologist utilizing SCAFT conceptualizes problems and intervenes in concrete situations. All names are, of course, fictitious.
Reflecting the traditional and preponderant use of the individualistic, psychodynamic approach to human problem solving and its adoption by lay culture, clients will generally formulate their concerns in terms of the characteristics of one family member, who is thought to be "the problem." It is assumed that this member needs to be changed in some way so that he or she will behave in a more acceptable manner. Often, an appointment will be requested for this individual in the hope that the problem can be worked out in therapy.

The first task of the clinician often becomes that of convincing clients (indeed, insisting to them) that all family members be present for the sessions. It is simply not possible to operate from a social situational perspective without having access to actual observation of the sequences of communication, hierarchical disputes, and general structure of the family system. The unit of analysis for interpretation of the problem and subsequent intervention is the group, not the individual.

An important element of the strategic communication approach is formulation of the client's problem in a clear way. The client will often seek therapy when he or she feels upset or troubled but will find it difficult to state unambiguously what the problem is. The clinician must formulate the present problem so that it is (1) clearly identified and (2) capable of being solved. For example, "depression" is a more amorphous and more difficult problem to approach than is "failure to hold down a steady job" (Madanes 1981:21). The latter is not only more amenable to solution, but the solution is subject to empirical verification.

Resolution of the presenting problem is the predominant concern of the therapist, who assumes responsibility for the achievement of this task and should not lose sight of it. The clinician working from a strategic communication approach views the presenting problem as a metaphor for a persistent pattern of interaction within a social unit. By working on the presenting problem, the clinician is working on the relationships.

In one case we encountered, Mrs. Wassons, a 26-year-old woman, married four years, complained of a "lack of communication" in her marriage and requested an appointment for herself. At the clinician's insistence she agreed to schedule the appointment for both herself and her husband. Lack of communication is an amorphous, multidimensional concern. During the first session, however, it became apparent that both spouses were unhappy with their sexual relationship. Mrs. Wasson was withdrawing from her husband's physical advances, to their mutual dissatisfaction. The clinician elected to focus on the couple's sexual relationship as the presenting problem. Sexual withdrawal was identified as a manageable concern that could be treated.

It became apparent that an asymmetrical distribution of power, favoring the husband, characterized the marital relationship. Digital bits of com-
munication indicated that the wife was responsible for most of the housework and childcare, despite her full-time job. She felt her husband unjustly withheld information from her concerning details of custody disputes he was having with his former wife. (By the previous marriage he had a six-year-old daughter who lived with his ex-wife.) Mrs. Wassons feared their relationship was being affected by these disputes, yet she was impotent to deal with the issue, given her husband's unwillingness to discuss it. Her complaint is a metaphorical one. Her dissatisfaction with the paucity of information represents a broader concern — her lack of informed participation in the marital relationship. Her withdrawal from sexual activity is a means of addressing this lack of control and, thus, becomes a metaphorical response to her lack of power in the relationship with her spouse. Withholding sex becomes one of the few mechanisms available to the wife for exercising power and influence in an otherwise asymmetrical relationship. By observing this hierarchical incongruity, the couple's marital problem can be understood as a consequence of an imbalance in the distribution of power. Indeed, this arrangement has created the presenting problem and even made the problem necessary.

A typical sequence of interaction occurs as follows: Mrs. Wassons seeks information from her husband to enable her to participate more fully in decision making. He brushes her off; she withdraws from him in response. He approaches her sexually; she rejects his advances, further withdrawing from him. Notice that both spouses are made unhappy by the lack of sexual activity. It is often the case that the method employed by a person to deal with an unsatisfactory social situation is unfortunate in itself: the solution becomes a further problem. Interventions at the level of the “solution” are likely to be more effective than attacking the problems directly and are referred to as the level of “second order change.” That is, the presenting problem is reinterpreted as a solution to a system-level problem (first order). Intervention by the clinician that affects second order change will ultimately affect first order change as well. The systems perspective on family interaction is critical to this approach. Thus, by sexually withdrawing, Mrs. Wassons is actually exacerbating the lack of communication she finds so ungratifying in the first place.

In the case of the Sanders, it was also the wife who first called to arrange an appointment. She told the clinical sociologist that she was “overly shy” and this was creating difficulties in her marriage. Although Mrs. Sanders was encouraged to make an appointment for both her husband and herself, she stated that her husband insisted she take the first step on her own (presumably as a first step toward overcoming her shyness). Since there was no alternative, the therapist agreed to see her alone for the first visit but emphasized that it was likely that Mr. Sanders would be asked to attend the next session and that Mrs. Sanders should advise him of this.
At the first interview it was apparent that Mrs. Sanders's complaint of shyness provided her with the opportunity to express dissatisfaction with her marriage. In particular, she felt that Mr. Sanders spent far too much time away from home, and when they were together, they were usually with other couples. Thus, they seldom spent time alone. This pattern was confirmed at the second interview, which Mr. Sanders attended. The clinical sociologist decided on a therapeutic strategy which initially would redefine the complaint of shyness in a less ambiguous way. The couple were told that Mrs. Sanders's shyness was simply a failure to assert herself and make her needs known. She was too accommodating of others to act in her own self-interest.

The presenting problem of the wife as "too shy" was similarly viewed by the clinical sociologist as a metaphor for power imbalance within the relationship. While Mrs. Sanders readily accepted the label of shyness to describe herself, it was apparent in individual interviews with her that she felt a considerable degree of resentment against her husband for his overall neglect of her needs and feelings. Mr. Sanders was ignoring their need as a couple for intimacy and time away from others. The wife's shyness was interpreted as a metaphor for both the couple's need for exclusive time together and an attempt to create a reason for such exclusivity. Unfortunately, since this solution by the wife meant that even the husband's family was excluded from their social life, it was a solution that fostered his resentment toward his wife — which resulted in the husband spending even more time away from home at his club. The result was a vicious circle analogically expressed in the wife's shyness and, at the same time, largely sustained by her response.

After identifying the social context of a client's problem, the therapeutic task is to shift the organization of the system in such a way that the presenting problem is no longer necessary. This is achieved by the assignment of directives that clients are required to carry out between visits. The aim of the directive is to change the patterns of interaction among family members, usually by offering a substitute for the problematic sequence of interaction that makes the presenting problem functional. Thus, the social system, rather than the individual, is the unit for therapeutic intervention.

For example, the Wassons' interactional pattern can be altered if the clinical sociologist can substitute a different method — one less dysfunctional than the present one — for affecting the asymmetrical distribution of power in the relationship. It was decided to deprive Mrs. Wassons of her power to withhold sex and to deal with the hierarchical incongruity by prescribing activities that would be more functional for the relationship, by their own definition. The couple were told that every evening they were to set aside fifteen minutes during which the husband would rub his wife's back. During this time she was to request information of him on any issue important to her. They would then be obligated to discuss the issue. Sexual activity was permitted only
The purpose of this directive is twofold. First, by restricting the sexual activity of the couple to two specific evenings, sex is no longer an arena available for the power struggle. By requiring the husband to enforced abstinence on other days, the previous pattern of interaction involving rejection is disrupted. Second, a more positive interactional sequence is substituted for the previous pattern. Symmetry is pursued through the soothing but nondemanding physical giving of the massage and discussion of matters important to Mrs. Wassons. At the same time, the directive addresses Mr. Wassons's frustration over his wife's refusal to engage in sexual relations with him by requiring her to participate twice a week. (Prior to this directive the couple rarely had sexual relations.) Reciprocity in the relationship is encouraged by a directive that replaces a mutually frustrating sequence with a more constructive one.

In the case of the Sanders, the couple were told that it was possible to cure Mrs. Sanders's lack of assertiveness, but that this could be achieved only with the husband's active participation. They were informed that Mrs. Sanders's wish that her husband spend more time with her would be the focus of treating her lack of assertiveness. Whenever Mr. Sanders was to be away from home for more than two hours (and especially on Saturday and Sunday while at his men's club), he was to inform his wife.

The clinician instructed the wife that in order to assert herself she was to go shopping instead of remaining home alone at these times. Furthermore, she was told to buy something for her own personal use. The value of this item was to be based on the number of hours Mr. Sanders was to be away. In addition, Mrs. Sanders was directed to select a day twice a month on which the couple would entertain Mr. Sanders's family. Mr. Sanders could not visit the men's club on those days since he would be required to assist in preparations for the visit in ways Mrs. Sanders considered appropriate.

This set of directives was based on redefining the presenting problem of shyness in a way that made it possible for the clinician to deal with the underlying problem of asymmetrical power. By redefining the wife's problem as one of a lack of assertiveness, the clinical sociologist was able to enlist the husband's aid in solving the problem. It also prevented the husband from ignoring his wife's need without incurring a cost — which is exactly what the wife's symptom of shyness was designed to achieve. To give Mrs. Sanders a sense of power over her husband's activities, especially the time he spent at the men's club, the shopping directive allowed her to influence the amount of time Mr. Sanders was away from home — something she had not been able to do in their two years of marriage. Finally, Mr. Sanders was given an incentive for complying with these directives by negotiating the couple's agreement to invite
his family to their home every other weekend. The aim of these tasks, as in the case of the Wassons, was to shift the pattern of interaction from one of mutual frustration to one of mutual satisfaction.

Conclusion

The strategic communication approach to family therapy represents a sociologically based model for the conceptualization of and intervention in everyday problems of social relationships. Sociological concepts such as power and control, function and dysfunction, system and interaction pattern, role and exchange, serve as a framework for relationship analysis. SCAFT is not the only sociologically oriented form of therapeutic intervention; it is, in our opinion, one that lends itself well to further explanation and development by clinical sociologists.

NOTES

1. We wish to thank the anonymous reviewers for the Clinical Sociology Review for their helpful comments on an earlier draft of this paper. For alternative approaches in clinical sociology to individual and family therapy — utilizing the social behavioristic perspective of G. H. Mead — see Hurvitz 1979 and Straus 1982.
2. For an interesting historical view of the child guidance clinic in relation to clinical sociology, see Wirth 1931.
3. For the sake of simplicity and because of space limitations, we have omitted reference to marital therapy and avoided entirely the question of its relationship to family therapy. It is our opinion that the distinction between the two is at present much less important than it was a decade ago. For a discussion from that time period, when the two could be seen independently, see Olson (1970).
4. Haley provides a connection not only between the two Palo Alto groups, but also between the Mental Research Institute and the Philadelphia Child Guidance Clinic where he consulted with Minuchin, Montalvo, and Erickson. In a sense this collaboration represents a fertile interchange between Bateson's communication ideas and Parsons's structural-functional perspective on the family.

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Clinical Sociology and Adolescent Medicine: The Design of a Program

David J. Kallen

ABSTRACT

This article describes the uses of sociological theory and knowledge in the design and operation of an in-hospital program for the care of physically ill and injured adolescents. The central tasks of adolescence — resolution of the conflict between autonomy and dependency, the development of intimacy and competence, the ability to take on adult roles, and the development of the self — may be hampered by a total institution which depersonalizes patients and fosters dependency. The development of normative structures which encourage autonomy, continuity of role development, appropriate levels of intimacy, and continued development of the self are encouraged by appropriate modifications of usual hospital routine. Normative support for these modifications is developed through educational programs for house staff (residents and interns), nurses, and others involved in the program. While the article emphasizes sociological concerns, the success of the program depends on contributions from an interdisciplinary team drawn from medicine, nursing, social work, and sociology.

Introduction

Clinical sociology has been defined as “the application of a variety of critically applied practices which attempt sociological diagnosis and treatment of groups and group members in communities” (Glassner and Freedman 1979:5). This paper discusses the ways in which sociological theory has been brought to bear on the development and operation of an in-hospital program in adolescent medicine. The presentation is purposefully biased in that it ignores the important contributions of psychology, medicine, nursing, and other disciplines to the program. Three areas are discussed: patient care; education of house staff (residents and interns), nurses, and others; and other uses of sociological theory in the program. Finally, some of the problems of program operation are discussed.
The program is run by a team that includes physicians, nurses, hospital administrators, social service personnel, and the sociologist. The entire group influences the decisions that are made, and the program could not be operated without the cooperation and collaboration of the entire group. However, the attempt has been to give this program a distinctly sociological flavor: the sociological viewpoint influences both patient care decisions and the education of residents.

The Development of Adolescent Medicine

Adolescent medicine is a relatively new health care specialty. Although the Medical Officers of Schools Association was formed in England in 1884 by physicians caring for public school students, specialization in adolescent medicine per se did not occur until after the end of the Second World War. The first inpatient unit for adolescents was established in 1951. The Society for Adolescent Medicine was not organized until 1968, and its journal published first in 1979 (Gallagher 1982). Physicians who specialize in adolescent medicine are drawn primarily from pediatrics and from family medicine. Three major trends within American society contributed to the development of the field. These are: the separation of adolescents into a social category, the recognition of the special health needs of the group, and more general demographic changes.

Development of Adolescence as a Social Category. In American society adolescents are marginal persons (Park 1950) who have neither the full rights and responsibilities of the adult nor the freedom and lack of responsibility of the child (Kett 1977). Educational requirements that extend beyond puberty and hence delay entry into full adult roles and statuses set adolescents aside as a separate group in society. For reasons related to social and psychological development, adolescents are often loud, self-centered, and boisterous, and they behave in ways that adult society often regards as both inconsiderate and disturbing. These behaviors may be merely annoying in other situations. In the hospital, where the actors in the situation may be desperately ill, these behaviors may have serious negative consequences. At the same time, adolescents are often uncomfortable being with either sick adults or sick children. This mutual lack of comfort is, in part, the consequence of the marginality of the adolescent in American society. Thus, both adolescent and adult health care is seen as benefitting from the provision of special organizations for the care of the adolescent.

Adolescent Health Needs. During the 1960s the changing behavior of adolescents, particularly the increase in the numbers of adolescents living away from home and the increase in adolescent sexual behavior, led to the
development of special clinics for this age group. Many of these clinics were started to provide care for drug users and birth control to adolescents. This initial concern with specialized health care led to a recognition of other, more general health needs of this age group, and hence to the development of inpatient and outpatient facilities for them.

**Demographic Changes.** Changes in the age structure of society and the reduction in family size have resulted in fewer infants and children requiring care, while the aging of the baby boom generation has meant there are more adolescents and young adults seeking medical care. At the same time the development of family medicine as a specialty that offers primary care from birth to death has created increased competition for pediatricians, requiring them to seek new areas in which to provide care. Because pediatricians are familiar with problems of development, they see the provision of health care to adolescents as a logical extension of their work.

**The Inpatient Unit at St. Lawrence Hospital**

The development of the adolescent inpatient unit at St. Lawrence Hospital is the result of all these trends. St. Lawrence Hospital is one of three allopathic (MD) and one osteopathic (DO) hospitals in the Lansing, Michigan, area; together, the four hospitals serve a community of about 400,000. As a Catholic hospital, it has a long tradition of providing humane, patient-centered care, particularly in pediatrics. St. Lawrence is affiliated with the College of Human Medicine at Michigan State University and is a training site for pediatric and family practice residents.

The adolescent unit was established in 1980, partly to provide a service not then available in the community and partly to provide training in adolescent medicine to residents in both residency programs. Underutilization of pediatric beds at St. Lawrence contributed to their interest in the development of the unit. It was hoped that the provision of a needed community service would also alleviate the financial burden that unused beds created for the hospital.

The unit itself is a combined adolescent-pediatric ward in a community hospital. It has seventeen beds in one single and eight double rooms on a single corridor, with a children’s playroom at one end and an adolescent recreation room at the other. The number of beds allocated to adolescent or pediatric patients varies depending on patient care needs.

The adolescent room has been clearly structured as a place where adolescents can go to be adolescents. It is equipped for their use with a Ping-Pong table, pool table, jukebox, etc. Access to the room is restricted to adolescents and their friends. Neither younger patients nor adults may enter the room without the permission of adolescents who are using it. No medical
procedures are ever conducted in the adolescent room. Hence, it can be a refuge from the trials of the hospitalization experience.

St. Lawrence Hospital was designed for patient-centered nursing. Nurses are expected to spend their time in the rooms with patients. Instead of the traditional nurses’ station there is only a small conference room to serve as a central gathering place. Charts are kept in cabinets accessible from the hallway and from the patient’s room. The rooms were designed to provide considerable privacy to the patient. This is ideal for the adolescent but less useful for the critically ill infant. At any given time there is a variable mix of adolescent and pediatric patients on the floor.

Unit and Program Goals

I was asked to help develop the adolescent program as an extension of pre-existing educational responsibilities in the pediatric residency program. It was clear from the beginning that the program would have to fit within the existing normative structures of the hospital and the residency programs.

In this community hospital, patient care decisions are ultimately made by the admitting physician, either directly or by the resident acting for him or her. Therefore, any impact on what happens to patients would have to be the result either of the way in which the program is formally structured or of an ability to influence those physicians who have the formal authority and responsibility for the patient’s care. The influence might be direct or might be the result of educating physicians. Sociological interests and concerns led me to consider ways in which the program might focus on the social development of the adolescent, with less concentration on the psychological dynamics that are of concern to more traditionally organized programs (Hofmann et al. 1976). In fact, I began with the idea that the unit could be designed so that the social arrangements would forestall many of the psychological problems others see associated with the hospitalization of adolescents. At the same time, participation in this new program would provide new opportunities and challenges for resident education.

Two major goals were developed initially, and a third after the program began. They are: (1) To establish a structure in which the provision of health care to physically sick or injured adolescents would enable and encourage them to continue working on the major tasks of adolescence. To do this, three subgoals were developed: (a) to develop and mobilize a set of resources that would be brought to bear in the service of the adolescent; (b) to change the adolescent patient role to be much more self-directive and active; and (c) to develop a strong social structure in which social norms could be a major means of achieving unit goals. (2) To educate health professionals about social life in general, and specifically about social structures, normative behavior, and ad-
olescent social development, so that they would act in ways that would support the goals and purposes of the unit. (3) To develop system maintenance activities that would insure the smooth operation and continuation of the program. This third goal was developed after the program began. These three goals will be discussed in turn.

Goal Implementation

Program Objectives and Adolescent Development. Hospitalization, particularly long-term, has the potential of interfering with the developmental tasks of adolescence. The St. Lawrence program has been designed to permit the adolescent patient to continue with normal development to the greatest extent possible. To do this, it may be necessary to deny the patient certain traditional aspects of the sick role (Parsons 1958), particularly the exemption from normal activities. It may also require a renegotiation of the traditional health care worker-patient relationship to permit the patient to take a much more active role.

Adolescence is a time of rapid physical, psychological, and social development. Two cognitive developments complicate the problem of designing appropriate social environments to permit continuing development. These are the development of the ability to think abstractly (Adelson 1975) and the development of the adolescent myth (Cvetkovich et al. 1975). The adolescent myth refers to the adolescent's belief that he or she is the center of the world, that everyone is paying attention to him or her, and that his or her reactions and experiences are unique (McKinney, Fitzgerald, and Strommen 1982).

Crucial tasks in social development include the resolution of the conflict between dependency and autonomy, the development of intimacy and competence, the ability to take on adult roles, and, of course, the development of self. Adolescents face specific problems because of their hospitalization and often face life adjustment problems in general. Various aspects of the program have been designed to encourage progress in each of these developmental tasks.

The resolution of the conflict between dependency and autonomy is one of the major areas that can be negatively affected by the hospitalization experience. The hospital is a total institution that depersonalizes the patient (Goffman 1961). Set routines reduce patient autonomy and infantilize the sick person while providing care and nurturance. This lack of autonomy and infantilization may be an appropriate implementation of the sick role (Parsons 1958) for critically ill adults but may be counterproductive for many adolescents. In the unit, autonomy rather than dependence is encouraged by giving the patient as many opportunities as possible to make his or her own decisions about what happens. These decisions are of various magnitudes,
ranging from involvement in the choice about whether or not to continue treatment to prolong life to something as trivial as whether a shot should be given in the left or right arm, or before or after lunch. A major attempt is made never to make a request if a negative answer to that request is not acceptable; for example, a patient will not be asked whether he or she wants a medication but may be given a choice of the medication now or after lunch. Patients are encouraged to do as much as they can for themselves, including many of the routine maintenance tasks often provided by nurses.

At the same time, unit policy and procedures recognize that many adolescents require a period of nurturant care, particularly during the early stages of an acute illness. Adolescents who have left their parental home and are living independently may especially benefit from a period of dependency during the intial acute stages of an illness.

**Staff Roles** Role discontinuity between the hospital and home may also interfere with appropriate development. To limit the impact of hospitalization and to provide role continuity, the adolescent patient is encouraged to continue to do schoolwork and to do as much self-care as possible within the limits set by the disease. The need for continuity of life experience also has led to the formalization of a clear division of labor among the staff. Thus, for example, parents, the visiting teacher, and the child/adolescent life worker have responsibility for supervision of schoolwork; nurses provide nursing care and are not encouraged to help with or supervise schoolwork. The child/adolescent life worker does not become involved in nursing care. These role distinctions help patients understand their own as well as the adult role responsibilities at a time when social control, nurturance, and intimacy might become confused. At the same time, the development of intimacy is not dependent on the formal role of the alter, and strong friendships may develop between patients and staff. Hence, the formal assignment of roles does not interfere with the development of special supportive relationships between individual patients and individual staff.

**Norms and Limits on Behavior** The opposition adolescents often show toward formal authority is a consequence of both their struggle with dependency-autonomy and their newfound cognitive skills that permit them to see multiple sides to every issue. The unit, however, must have clear regulations about permitted and not permitted behavior. Hence, smoking is limited to certain designated areas. Nonprescribed drugs and certain forms of sexual behavior are prohibited, and visiting hours for friends are limited. The regulations are presented to the young person on admission as part of the normal — and normative — structure of the unit. Much conflict is avoided through communication to the patient that these are the rules of the house, implemented for reasons of health and for the consideration of other patients and not for moral reasons. At the same time, the rules are not rigidly and arbitrarily enforced;
visiting hours are flexible and a patient with a special visitor of the opposite sex may be permitted limited stay.

**Group Process and Individual Intervention** Hospitalization may interfere with the development of the self by removing the adolescent from usual daily routines, and the illness-hospitalization experience may make the adolescent feel vulnerable in new and unique ways. Thus, adequate development may be foreclosed. While individual counseling from social workers and psychologists is available, group process is also used to help the adolescent deal with the stresses of illness, hospitalization, and the new awareness of his or her own mortality. When there are enough patients in the unit and sufficient interest among them, group lunches are held in the adolescent recreation room. All adolescent patients are invited, though it is made clear to each patient that he or she has a choice of whether to attend. The discussion is initially structured around issues dealing with the illness and hospitalization experience, but it may move on to other areas of life. Because of the adolescent myth, adolescents are particularly vulnerable to the belief that no one else has ever had their experience or could understand it. The group discussions often demonstrate a similarity of experience, which helps the patients integrate the experience into the continuity of individual and social life.

At the same time, the other patients and the staff function as strangers; that is, the young person feels confident in sharing with these strangers ideas and concepts that would not be shared with those whom the adolescent expects to know after the hospitalization. This sharing with strangers is enhanced by their coparticipation in a situation in which the roles expected of and demands on the adolescent patients are ambiguous to them. Hidden or unrealized aspects of the self are often revealed in these situations, in part because those with whom they are shared will not continue to be part of the life of the adolescent. They will be left behind when the hospitalization ends, and the parts of the self here revealed will not provide feedback to the adolescent about other parts not revealed in the nonhospital situation. Thus, other persons in the situation act at Simmelian strangers (Wolff 1950).

It is also possible that the safety of this interaction with relative strangers enables the adolescent to experiment with new aspects of the self in ways that are not possible with persons with whom the patient will continue to interact. It is interesting to note that the adolescents are conscious of the importance of their initial presentation of self in these meetings. They will often make sure, for example, that they are well groomed in order to present as favorable and normal an external self as possible.

The adolescent lunches were started during a period when there was no child/adolescent life worker, and they were well received. For reasons which are not clear, interest in them dropped when a more individualized recreation program was started with the employment of a child/adolescent life worker.
**Individualized Intervention** The stress and strain of the hospital experience, or events in the life of the adolescent before hospitalization, may require individualized intervention. Both social service and psychological personnel are available to provide individual counseling. To discover which adolescents would benefit from these interventions, when resources permit, the social worker routinely visits each patient. The routinization of this initial interaction establishes it as a normatively appropriate experience which occurs on the unit. This significantly reduces the possibility that the adolescent in need of individualized help will be stigmatized by himself or herself, by the health care system, by peers, or by others as a result of the help-seeking behavior. Even when resources do not permit routine visitation of each patient, frequent visitation and response to informal referrals ensure that a visit from the social worker is not regarded as an unusual or remarkable event.

**Social Intervention** Some adolescents behave in ways that create problems for themselves and for others, particularly in their refusal to behave in socially acceptable ways and in conduct which disrupts the social order or disturbs others in the social environment. This acting out may be continuous with prehospitalization behavior or may be specific to the hospital experience. When the source of the behavior is regarded as psychological, appropriate psychological therapy is provided in an attempt to change the internal psychological structure of the individual and thus modify behavior. This individual therapeutic approach is often slow and expensive. But behavioral change can also be achieved by the use of clear social controls in clearly defined social structures. One example of this social intervention began one Friday afternoon when the nursing staff requested assistance with a 15-year-old female whose behavior was causing problems. Unacceptable behaviors included throwing her food tray across the room, ripping her bed apart, and refusing to communicate with the nurses. The nurses involved in her care felt that her behavior was not good for her, and they were also angry about the additional work her behavior caused them. They were unsure about how to modify her behavior. The patient appeared to be responding to a lack of a clear social structure to guide her behavior, with no clear negative sanctions applied when she behaved in unacceptable ways. The intervention chosen was to control her living situation in a way that would make it clear that her own inappropriate behavior had negative consequences for her. That is, if she threw her food tray, she would be expected to clean up after herself; and if she ripped her bed apart, she would sleep in an unmade bed. Thus, norms about appropriate behavior were made clear to her, and the consequences of norm violation became self-correcting by her choice. Over the course of two or three days her problematic behavior significantly decreased as she took responsibility for the consequences of her own behavior in a clearly structured situation. This regimen, of course, violated the expected caring and nurturing role of the
nursing staff. The nurses needed some initial reassurance that this change in their traditional role would be in the best interests of the patient. It is to the credit of the unit staff that they were willing to try this intervention. As the patient’s behavior improved over the weekend, the nurses became highly supportive of the regimen. Program staff have continued to look at ways in which structural elements can be used to reduce problematic behavior on the unit.

**Educational Programs.** The second major goal is the education of health professionals, including house staff and attending physicians, social service staff, and others, including myself. Two major processes are used: grand rounds and regular ward teaching rounds.

**Grand Rounds** Grand rounds are formal conferences in which one or more individuals present a topic of interest to the attending physicians and house staff. Traditionally, these grand rounds are medically oriented, often reviewing a specific disease or new treatment regimen, occasionally reviewing a complex case. Adolescent grand rounds are held once a month. Because it is necessary to meet the normative requirements of a group in order to bring about a change, adolescent grand rounds have been a modification of and not a departure from the traditional format.

Behavioral concepts have been included as part of a more general discussion rather than being the exclusive focus on the conference. Thus, for example, in a conference on short stature in adolescence, the major presentation was on the endocrinological causes of short stature and its treatment, but the social, psychological, and behavioral consequences of height deviance also were discussed. Another presentation about an adolescent who attempted suicide by hanging herself included brief presentations on the physiology of neck injury, the psychiatric view of adolescent suicide, the social setting of the adolescent and her family, and the in-hospital care of the suicidal adolescent. These conferences have a general educational aim; attempts to teach pure sociology — or even to focus exclusively on behavioral concerns — would meet resistance from the house staff and the physicians for whose benefit they are presented. At the same time, it has been possible to integrate behavioral information in meaningful ways.

**Ward Rounds** Ward rounds and ward conferences deal with the day-to-day business of the unit and with patient treatment. They are usually attended by a number of individuals, including the house staff, one or more attending physicians, nursing staff, social work staff, and myself. Attendance and topic are very much a function of the particular patients receiving care in the unit on a given day. The primary purpose of the unit is the medical care of the adolescent, and purely medical issues may take priority in these conferences.

When it is appropriate to discuss the behavior (as opposed to the physiology or medical condition) of the patient, I often try to be self-
Consciously sociological, without labeling my input as such. One major use of sociological perspectives is to help house staff become aware of the alternative definitions of normality and deviance that must be applied to social life and social events. Following Durkheim (1938), sociologists define normal in normative terms; normality and deviance are thus statistical and related to the social life of a given social organization. Medical theory and medical practice have a very different definition of deviance: deviance refers to difference from an absolute standard. A body temperature of 100 degrees is deviant; normal temperature is 98.6 degrees. A hemoglobin of six is dangerously below the normal range of twelve to sixteen. These are absolutes; deviations from these biological normals are deviant in all societies. (It is true that a whole population may have a deviant biological value — that is, a low hemoglobin. While the individuals may adapt to this, medically they are still abnormal and therefore ill.)

Medical personnel are more comfortable with the definition of deviance as absolute difference from an absolute standard, rather than viewing it as a difference from arbitrarily or statistically defined norms that may shift from subgroup to subgroup. Understanding patient behaviors and responding adequately to them may depend on the health care personnel learning the social definition of deviance. Education on the extent to which behavior is rooted in social life and social experience, and why normality and deviance may vary from patient to patient, is a constant theme of these discussions. This education is best accomplished through the use of examples, although sometimes it is possible to introduce small amounts of data (such as differences in the proportions of adolescents involved in coital relationships between 1950, 1960, 1970, and 1980 as a way of indicating that behavior which was deviant in one era is normal today).

Mini-lectures often provide a useful way of giving additional information and knowledge. Busy ward staffs do not have the time nor the inclination to listen to long lectures with the usual sociological qualifications about generalizability or applicability, which are so much a part of academic sociology. A three-minute discussion of some aspect of social life and a two-minute discussion of how this knowledge may affect some aspect of patient care are appropriate in this situation. The challenge to the clinical sociologist is in translating sociological knowledge into behavioral applications that are useful in the care of a particular patient with a particular disease at a particular time with a particular physician. Thus, brief discussions of the development of the social self and the extent to which children's and adolescents' behavior is based on the reactions they receive from others helps the health care staff to understand the responses they receive from given patients. Similarly, a brief discussion of the extent to which hospitalization is depersonalizing and of the importance of an appropriate presentation of self in such settings helps the
staff to see why it may be more important to the adolescent to be permitted to wash her hair than to provide an additional bit of history at the convenience of the staff.

Ward conferences also deal with the day-to-day business of operating the unit. It may be necessary to examine sociological issues involved in the unit organization and structure (although, again, without labeling the discussion as sociological). Role relationships between residents who come from two different residencies may need to be negotiated. It may be necessary to review how and why certain decisions were made or to examine the structural reasons for a breakdown in patient care. It is sometimes necessary to examine why a patient was admitted, or not discharged, and the extent to which social and psychological factors entered into these decisions. The consequences of these decisions for the patient and for the unit are reviewed. This process aids in establishing the limits of care to be provided on the unit. As Erikson (1966) has pointed out, the definition of what is regarded as deviant establishes the limits of normality. The review of unit decisions helps define the scope of the program to be offered and helps identify structural problems in implementing the program.

System Maintenance Activities. No system operates automatically, and the adolescent unit is no exception. A good deal of attention has to be paid to system maintenance activities. I am struck by the extent to which it has become my role to be concerned with certain recurrent processes. One of these is the failure of the workers in the system, if unreminded, to provide the patients with the opportunity to participate as much as possible in normal life activities and do as much as they can for themselves. While part of the sick role is to participate in activities which improve health, part of the role of being hospitalized is to be passive and to be acted upon rather than acting. Physicians are socialized to command and direct, nurses to care for and nurture, sociologists to study and analyze. It is often counternormative to have the patient highly involved and active in his or her own care. It has become my role to remind the health care staff of the importance to the adolescent of having as much control over his or her own destiny as possible. This is often accomplished by a simple review of activities; or by asking, for example, whether the patient has been to the adolescent room, or has been encouraged to make his or her own bed.

I must also constantly remind the staff of alternative realities that affect both patient and staff behavior. Behaviors that make sense to staff may not make sense to patients, considering their total life situation, and vice versa. Health care staffs' assumptions about normal behavior, acceptable morality, or deviance must be constantly questioned and examined. Social trends and social reality must continually be presented. For example, the statistics on adolescent pregnancy in the United States indicate that because of the risk of
harm to the fetus, every pubescent female must be considered pregnant until demonstrated not to be, although that demonstration may be by history rather than by laboratory examination. Failure of the health care providers to consider the possibility of pregnancy could put some patients at risk by using procedures that could harm an unborn child. At the same time, health care staff, and particularly physicians, often need to be reminded that sexual behavior is normal for these adolescents and a mere report of sexual activity does not indicate the adolescent is deviant.

My presence at rounds also serves to remind the health care staff of dimensions of patient care that should be considered and that they know are important but may overlook under the press of dealing with more physiological issues. This reminding function is not unique to the role of the sociologist but is the result of the presence at rounds of any behavioral scientist in our program. I do think, however, that the concerns about deviance and the sick role are relatively unique to the sociological perspective.

**Some Limitations on the Sociologist's Role**

In this paper I have not discussed issues of direct patient care by a sociologist because in my program I do not provide direct care. There are several reasons for this. First, my training as a sociologist did not prepare me for direct personal counseling or other forms of individual intervention, and I am aware of the dangers of amateur intervention and feel uneasy about it. Second, there are structural reasons for working with and through other people, rather than directly with patients. The most important of these is that in the present system the admitting physician, the house staff, and various hospital employees have the formal legal authority and responsibility for the care of the patient. Because of this I feel obliged to defer to the judgment of these others even when I do not agree. At the same time, I think that one of the reasons that I can have an impact on the program is that I have been willing to leave the protective ivory tower of an academic office to work side-by-side with residents, nurses, and attending physicians, attempting, just as they do, to translate what I know into a healing process for the patient.

As indicated in the beginning, the description of the program is somewhat idealistic. For a variety of reasons, including the economic situation in the state, the absence of a physician specially trained in adolescent medicine, and competition from other hospitals that offer specialized medical care for specific illnesses, the number of patients hospitalized at any given time has often been less than desirable for the optimal operation of the program. While the program can provide a better socioemotional experience for the physically sick or injured adolescent, the total welfare of the patient may indicate hospitalization in a unit where specialized treatment (for cystic fibrosis or
leukemia, for example) is both available and routine, rather than on the adolescent unit. Economic problems of the region have resulted in a general decrease in the seeking of health care, including that among adolescents. These problems, which are external to the operation of the unit, still significantly affect what can be done within it.

**Conclusion**

In this report, the role of the sociologist and the contribution of sociological theory in the design and operation of the program have been emphasized, and the contributions of other disciplines and specialties relatively ignored. In actuality, the program functions because of the contributions of individuals from a number of disciplines who have learned to work together toward the common goal of providing a better environment for the ill or injured adolescent. If I have been able to teach some aspects of sociological theory to my colleagues that might be used to help guide decisions in the unit, I have also learned a great deal about medicine, nursing, social work, ways of providing meaningful leisure-time activities to the hospitalized patient, and so on. The sociological perspective may add a unique character to this particular program, but in the final analysis it is the interdisciplinary team that enables it to function.

**ADDENDUM: Two years later: the failure of the promise**

In the spring of 1984 the program was considerably reduced in scope and intensity. This addendum briefly describes the present situation and the reasons for this reduction in program scope.

The major unsolved problem was to maintain sufficient patient volume in the unit to enable the program to operate continuously and effectively. This problem was discussed in the original presentation, but was never solved. (The reasons for low patient volume were suggested earlier.) The lack of sufficient patient volume has had a number of negative effects on the program. First, cost considerations have led the hospital to utilize empty beds on the unit for adult orthopedic patients. Although the hospital administration has supported the adolescent program, the shift to diagnostically related groups (DRGs) for reimbursement increased pressure on hospitals to control costs; this made it impossible to carry empty beds in the hope that adolescent patients would use them. Filling the unit with adult (and often quite aged) orthopedic patients has, in turn, resulted in nurses and the child and adolescent life worker having increased responsibilities for the care of older patients, hence less time to devote to the adolescents. The adolescent room has been reorganized to serve
the leisure time needs of adult patients as well; it is no longer available as a safe haven for the adolescent.

Hospital cost considerations also reduced the presence of the social worker in the unit. Instead of being able routinely to visit every adolescent patient, the social worker now responds primarily to requests for consultation. Making up for the reduced presence of the social worker is the increased presence of the child and adolescent life worker, whose role has been expanded to include helping adult orthopedic patients. These changes are the result of decisions by the hospital administration about the most effective utilization of scarce resources for the entire hospital.

A major shift has occurred in the educational program offered to the pediatric and family practice residents, partly as a result of low patient volume, and partly as a result of an inability to provide adequate resident involvement with many of the patients on the unit. In the early stages of the program, an attempt was made to have the resident assume some level of responsibility for all patients on the floor, not just those being cared for by pediatricians and family practitioners. Many of the adolescents are surgical or orthopedic patients, and while there is no problem in involving them in program activities, arrangements were never made to have house staff involved in their care. As a result, the educational emphasis moved from in-hospital to outpatient, with the resident on adolescent rotation spending a good deal of time in clinics which treat adolescents rather than in the hospital. As of this writing, the resident educational program in the hospital consists of two weekly conferences, one concerned with patient management and one primarily didactic.

I attend and help organize the two weekly ward conferences, but no longer routinely make rounds on the ward because of the decision to have the resident on adolescent rotation spend most of his or her time outside the hospital. Patient management rounds are no longer made in the way they used to be, and the team has reduced involvement in patient care.

Does this mean that the program has failed? No. Good things are still more likely to happen for adolescents at St. Lawrence than in other hospitals in the community. At this point, however, the program is not the success that it was two years ago. Perhaps the promise that it showed then will never be reached. A number of things could have been done differently, the most important being to ensure that residents were involved in caring for all patients on the floor. Such adjustments would probably have resulted in only marginal improvement. The crux of the diminution of the program is the failure to have adequate patient volume; this problem is beyond the control of the sociologist working within the hospital.
NOTES

1. This is a revision of a paper given at the session on Clinical Sociology at the Tenth International Congress of Sociology, Mexico City, August 1982. The author thanks Andrea Doughty, William Rittenberg, and Patricia See for their helpful comments on earlier versions of this paper. Any shortcomings are, of course, the responsibility of the author.

2. It is impossible to give adequate recognition to all the people who played a major role in the development and operation of the program. However, there are three people who deserve special recognition: Andrew Hunt, MD, who serves with me as co-director of this program (Dr. Hunt recently returned to the program following the completion of his fellowship in adolescent medicine; he was away during the time period discussed in this article); Satish Gupta, MD, who has provided invaluable daily support to the program and a great deal of advice and support to me personally; and Marge Kizlowski, RN, chief nurse of the unit. I must also mention the nursing staff who have made the program work.

3. Michigan State University has three colleges of medicine: veterinary, human, and osteopathic. Human medicine trains Doctors of Medicine while osteopathic trains Doctors of Osteopathy. Neither college has its own hospital; rather, students and residents are trained in affiliated independent community hospitals that have various degrees of affiliation with the College of Medicine and in the university's outpatient Clinical Center. The pediatric residency program is operated by an independent corporation in which the College of Human Medicine and the three allopathic hospitals are equal partners. The family practice residency program is jointly operated by the College of Human Medicine and St. Lawrence Hospital.

4. St. Lawrence had an adolescent unit, run by a single physician, from about 1974 to 1977, when the physician left the community. Much of the architecture, including the design of the adolescent room, is a result of plans made during this earlier period.

5. Had this intervention not worked, the consulting psychologist suggested that a strict behavioral modification program be instituted. In such a program, the patient would have been placed in a "token economy," earning privileges through "good" behavior and losing privileges for "bad" behavior.

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Organizational Development: An Assessment with Implications for Clinical Sociology

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ABSTRACT

This paper examines organizational development (OD) as a clinical sociological strategy. OD techniques are diverse and include interventions ranging from stress management to quality-of-work-life programs. Strengths and weaknesses of OD approaches and reasons for the recent reemergence of interest in organizational and human resource development are explored.

Four specific criticisms of OD are discussed: (1) lack of congruence in values, cognition, and action; (2) failure to examine meta-assumptions and values of organizational problem solving and learning; (3) simplistic understanding of organizational politics; (4) inability to create internal changes that deal with external complexity and environmental turbulence.

Three issues are raised: (1) the proper unit of analysis for clinical sociological action research; (2) the incorporation of macro-level concepts like culture and systems in conceptualizing organizational development and change; (3) the identification and explanation of learning constraints under which organizations and individuals operate.

Introduction

This paper examines the relevance of current issues in organizational development (OD) for clinical sociology. Critical observations of the field of organizational development will identify structural and value problems facing practitioners working for planned change. The observations derive from practice, case studies, materials presented at OD conventions, interviews with OD practitioners, and a review of the relevant literature. This paper aims at a critical and selective integration of OD insights and clinical sociological practice.

Clinical sociology was first defined by Wirth in the 1930s as a respected sociological field. It has recently surfaced with a more focused identity which
"brings a sociological perspective to interventions and action for change. Its value orientation is humanistic, holistic, and multi-disciplinary" (Glass 1979:513-14). Glass and Fritz (1981:351-52) criticize OD's social psychological focus because it ignores "structures, goals, and environments in which problems are rooted." However, sociological critics of OD selectively incorporate some of its more clinically oriented intervention techniques.

Glass highlights the role of clinical sociologist as catalyst for clarification of client alternatives and helping clients develop their own problem-solving strengths. Intervention may occur at a variety of levels in the social system: individual, group, organization, community, or society. Some theorists in clinical sociology claim that it follows a tradition of grounded theory, activist research, and dialectical methodology (Glassner and Freedman 1979; Glassner 1981). Perhaps the strongest claim of clinical sociology is to a client-centered collaboration, including sensitivity to cultural traditions of client groups and an awareness of the ways in which the structural embeddedness of interlocking problems affects organizational behavior and structures.

Overview of Organizational Development

Researchers and practitioners have conceptualized the field of organizational development in various ways. For example, Gordon Lippitt (1982) defines it as "any planned organization-wide effort to increase the effectiveness and health of an organization through various 'interventions' in the organizational process using behavioral management sciences as technologies." Huse (1980:3) sees the general purpose of OD as "a process by which behavioral science principles and practices are used in a planned and systematic way to attain such goals as developing greater organizational competence, bringing about organizational improvement, improving the quality of work life and improving organizational effectiveness." Burke (1982:3) offers the following definition:

OD involves consultants who try to help clients improve their organization by applying knowledge from the behavioral sciences. . . . Most would also agree that OD implies changes and, if we accept that improvement in organizational functions means that change has occurred, then, broadly defined, OD means organizational change. The distinction between improvement and organization change may not be clear, however, and it is this distinction that compounds the problem of defining OD.

There appear to be two general and somewhat conflicting definitions of OD. One emphasizes structural components while the other places greater em-
phasis on human relations interventions. The structural emphasis focuses on design, structure, social-technological interdependencies, task activity, and organizational/environmental congruencies and contingencies. This approach includes quality-of-work-life projects, work redesign, Management by Objectives programs, collateral organizations, quality circles, and other system-level approaches. The human relations emphasis includes sensitivity training, team building, Tavistock-style conferences, transactional analysis, career-life planning, interpersonal confrontation, stress reduction, time management, process consultation, role negotiations, and group diagnostic meetings (Huse 1980:330-93; French and Bell 1978:117-30, 139-49, 150-76; Lippitt 1982; Burke 1982; French, Bell, and Zawacki 1983).

The common core of these two approaches is a surviving commitment to the essential belief that organizations and the workplace can function democratically to promote human potential and effectiveness. Early efforts by such pioneers as Chris Argyris, Warren Bennis, Ronald Lippitt, Elliot Jaques, Renis Likert, Eric Trist, Harry Levinson, Gordon Lippitt, Richard Beckhard, Robert Blake and Jane Mouton, Leland Bradford, and Edgar Schein are still being refined by ongoing projects and consulting work. Recent thinking about OD issues has been stimulated primarily by the growing perception that Japanese organizations maximize both worker involvement and superior quality products. The importance of strategically developing the fit of technical and social systems in the workplace is being recognized. Previously vulnerable programs for developing human resources move from being "luxury" to "indispensable" in order to achieve long-term organizational goals, and produce quality products, harmonious work relations, and organizational effectiveness. Clinical sociology infuses OD with more flexible techniques of integrating micro and macro approaches to social and organizational change. The sociological perspective elucidates the latent dimensions of planned change, identifies hidden agendas, and examines the congruence of technologies and democratic values.

Much current work in OD is based on a conception of planned change that assumes that it is possible to find value-neutral facts and solve problems once and for all. In contrast, OD in the action research tradition assumes the effectiveness of a collaboration between consultant and client, with an emphasis on the development of ongoing learning systems. This in turn requires constant problem solving that allows for uncertainty, inconsistency, and slippage. This view further stresses the need for clients to participate in the formulation of their own questions and the devising of their own answers. It is a multidisciplinary approach that is compatible with the diagnostic thrust of clinical sociology and the symbolic interactionist perspective. A more specific discussion of OD's strengths and weaknesses will highlight issues that also concern clinical sociologists.
An Assessment of OD Problems

The first problem with OD concerns what Tichy (1974:164-82) identifies as congruence in values, cognition, and action: whether or not consultants take action consistent with their stated values and cognitive assessments in the process of facilitating change. Tichy (1974:179-82) found that consultants were consistent with their cognitive model of change, but inconsistent in their commitment to stated democratic values, in both decision making and action. This contradiction appears because consultants are often hired to improve productivity, boost morale, or resolve conflicts as last-ditch strategies to save the organization or specific leadership cliques.

Tichy argues that OD consultants must create congruence between values and action and deal with their own "internal conflict" with sponsors. Value differences are expressed by contingent approaches versus normative approaches (Burke 1982:11). In the contingent approach, OD practitioners facilitate change only in ways decided upon by key client actors, typically top leadership. Facilitation of change places the consultant in a more reactive and passive role. In contrast, the normative approach emphasizes action research and participation in ongoing learning systems and change projects. In the latter, minority view (Burke 1982:111-12), collaboration is required, but consultants bargain for open, humanistic, organization-wide changes: decentralized power, just reward systems, democratic decision making, development of the whole employee at all organizational levels. Much OD supports a contingency approach. Although there are practical arguments for the conduct of OD in settings where organizational change is unwanted and suspect, contingency thinking often results in treating symptoms, providing piecemeal minor changes, and supporting expediency. These approaches often treat only symptoms, ignoring underlying problems that persist when the consultant leaves. Normative approaches require intervention plans that acknowledge the true effort required of those committed to organizational change. If those in power, either individually or collectively, are not committed to change, the normative approach obviously cannot serve as a model.

Clinical sociology faces the same difficult dilemma. Does it focus change efforts on the real world as it is? Should it help people cope with oppressive situations and organizational structures, or attempt to establish lasting system changes? Can incremental problem solving and contingency thinking provide the needed roots for ongoing and more significant reforms at a later date? Is it possible to establish a normative and humanistic clinical sociology without assuming an impractical, utopian vision and prospects for constant failure? What is the price for the institutionalization of humanistic and democratic clinical sociology? These questions, derived from OD settings, equally apply to practice with individuals, communities, or other groups.
A related problem is OD's excessive reliance on the latest interventions that serve the consultant's needs, training, and style. Consultants often use interventions they are familiar with, which lead to satisfied clients, professional recognition, and financial rewards. Consultants must carefully consider the reasons the client is asking for intervention and how committed organizational leadership is to ongoing and meaningful system change. Client motives that impair normative OD include: offering OD as extra reward for work well done; being included in the trend toward OD; gaining approval and advancement; increasing morale; and selling unpopular changes. Part of working toward significant change involves normative collaboration with clients; this in turn means understanding client motives that fit meaningful and humanistic change into organizational systems, leading to stronger problem-solving capabilities. Intervention strategies are then devised to fit the situation.

The second weakness of many OD interventions results from the failure to examine fundamental values or meta-assumptions of organizational problem solving and learning. Traditional OD intervention addresses this issue of problem solving in what Argyris (1980:15) and Argyris and Schon (1978) call single-or primary-loop learning. Single-loop learning occurs when the detection and correction of error permits the organization to compromise change efforts by supporting mere adjustments on the part of workers and status quo policies and goals on the part of management. Single-loop learning is based on the following assumptions: (1) the systematic blindness of people using traditional models of organizational learning; (2) competitive win-lose dynamics; (3) interdepartmental rivalries; and (4) organizational political games people use to protect themselves. Each of these loops leads to deception, lying, and protective behavior. Since such behavior is often not officially supported, it operates in covert and obscure ways. Individuals in such organizational settings often subvert the best organization development plans because truthful or clear information is routinely made ambiguous, vague, and inconsistent (Brunner 1973).

Many OD efforts do not address the need to challenge single-loop learning that impedes institutionalized organizational learning processes and system-wide problem solving. Double-loop learning, in contrast, builds upon a critical examination of the underlying values governing any social or organizational system.

This problem is related to the issue of organizational development's one-sided intervention at the request of management, a situation that promotes behavioral interventions and values conducive to management control and worker subordination. Many OD consultants support contingent intervention or "whatever works for management" because they ignore humanistic and democratic values. This "organizational imperative" view can be criticized as one-dimensional and elitist. In the name of doing OD, a climate supportive of
collaborative conflict resolution is often ignored in favor of behavioral control of workers. The normative approach educates management about worker sub-cultural values and motives that support meaningful participation and involvement in decision making and problem solving. Alienation, noninvolvement, and work-related problems result from a closed organizational cultural climate and single-loop learning and information systems. OD consultants often fail to recognize that they operate under the same informational and cognitive constraints as client and workers. A true action research strategy allows consultants to question the metatheoretical framework that guides both individual and system behavior.

Many OD consultants ignore the underlying dynamics of how organizational members create systems that constrain and control their own activities in order to make life manageable. Argyris recommends transferring learning from OD interventions back into the workplace by breaking down the distinction between basic and action research: basic research provides understanding, which then informs action; action research, to be effective, must “call to question the defensive structure of individuals and that in turn may trigger the defenses of the social systems in which actions are embedded” (Argyris 1980:13). OD strategies most often fit into single-loop learning systems that seriously limit “the actor’s learning capacity, especially when the issues are important, ambiguous or threatening” (Argyris 1980:14). Organizational members then cannot challenge system-wide problems without questioning underlying values. Action researchers cannot rely solely upon traditional methodological techniques because that tacitly hinders critical reflections and dialogues (Argyris 1980:21).

Glaser and Taylor (1973:145) found that OD projects that make a positive difference in client organizations involve consultants who probe, explore, keep communication channels open both within and outside of the immediate environment, and solicit criticism by utilizing committees, critics, liaisons, linkages, and broad-based contacts. Although there is not one best way to consult, this approach requires a humanistic commitment to facilitating client strengths. Burke (1982:360) calls this the marginal consultant role:

Remaining marginal, at the boundary of interface between individuals — especially bosses and subordinates — and between groups and systems is critical. . . . The consultant functions in the organic way, attempting to intervene in a timely manner and according to what the client needs at the time. Consulting organically means that the practitioner must use himself or herself as an instrument — sensing client need by paying attention not only to what may be observed but also to his or her own feelings and intuitions.
OD specialists who operate as scientists trying to apply principles of traditional pure research have often failed at changing organizational environments because they have not adequately conceptualized the cultural dynamics of organizational life. Such a view ignores the difficulty of shifting organization-wide norms and values toward a more humanistic direction. On the other hand, psychocultural strategies adopted uncritically by consultants overemphasize the need to improve the organization/worker fit by resocializing the worker at the expense of a more mutual collaboration in the change process (Lewicki 1981). The clinical sociologist brings to the situation methodological skills and sensitivity to cultural/structural issues that can avoid these consulting pitfalls.

Any attempt to help organizational members improve organizational rationality through increasing learning, collaborative feedback, no-fault problem resolution, and system-wide bargaining makes sense only if relevant information and supportive attitudes are widely available in the organization. However, in many situations sponsorship for change is ambiguous; consultants are called in because problems have become "messes" or have grown into a system of unresolved problems (Ackoff 1981).

The third criticism regarding OD is its often simplistic view of organizational politics and power. Pfeffer (1981:7) sees power as "a property of systems at rest: politics is the study of power in action." Brym (1980:26) defines power as "the structurally determined capacity to control others by deciding issues, by deciding which issues are to be contentious, and by suppressing manifest and latent conflicts." Power includes both the ability to initiate action and to resist or stop activity. The traditional view of power in organizations overemphasizes its legitimate basis. In contrast, power in action involves politics, the interpretive side of organizational bargaining for resources, where subordinates often resist actions they view as arbitrary (Clegg 1975; Baumgartner 1977; Lukes 1976).

Many OD writers downplay power, or when they do recognize it, they define it in a negative manner. For example, Varney (1977:219) defines power-based activity as "reliance on force or its residues or as a status position carrying negative connections." French and Bell (1978:258) mention the limited role of power in traditional OD models, but they fail to explore the implications of this weakness: "... organization development seems restricted in its models regarding effective use of power in organizations. Stemming from the laboratory training method background, models of change typically involve love-trust ... (and underplay the importance of power)." Further, many OD consultants using a contingency model ignore the importance of organizational resources such as position, information, access, and coalition membership. Brute power is often legitimized by assuming value and goal consensus. Yet, under conditions such as resource scarcity, competition, plurality of
coalition goals, or repressed bargaining tactics, it is inevitable that conflict and power struggles will emerge. In such contexts OD consultants often fail to see politics and power covertly clothed in the rational guises of bureaucratic rules, standard operating procedures, chain of command, and cultural values taught as "that's the way things are around here."

Such use of power by management, even if legitimate, does not neutralize the other side of the power equation: the phenomenon of power-created resistance. Resistance cannot be avoided; in fact, it is a sign of healthy involvement. It signals the need to recognize that involved and rewarded workers are often more productive than those who perceive a lack of praise and reward and who feel excluded from meaningful involvement in the decision-making process. Successful leaders must recognize the reality of conflict over resources and learn how to induce compliance in a humanistic way in order to mitigate negative or destructive resistance. This conflict model recognizes that consensus is not always possible or even healthy (Clegg 1975) and that attempts to avoid worker participation, bargaining, or resistance can lead to secondary effects such as worker passivity, alienation, and noninvolvement. These effects in turn contribute to deterioration of managerial legitimacy, a decrease in morale and productivity, and an increase in absenteeism and turnover.

Sennet recently addressed the complex issues of authority and power. Authority, he claims, is often distorted by fear, paternalistic impulses, and autonomy without compassion. He suggests that "the dominant forms of authority in our lives are destructive; they lack nurturance... (which is) a basic human need." He identifies the following tactics for breaking the bonds of arbitrary domination (e.g., power) in the chain of command: (1) refuse the active voice in the chain of command in order to counter bureaucratic language; (2) openly discuss categories and rules; (3) create discourse about the nature of obedience; (4) exchange roles; (5) openly discuss nurturance (1980:120; 180-90).

Humanistically oriented clinical sociology also supports the view that illegitimate authority and unnecessary domination can be overturned by the proper exercise of power on a human scale, by mutual compassion, and by nurturant behavior. The fight against arbitrary power is a constant struggle because it is easy to fall into the trap of converting power into such metaphorical security blankets as the belief in paternalism: "Management always knows best."

If organizations are to resolve essential problems, and if both organizations and workers are to achieve their true potential, both must revise their understanding of power. Power cannot be treated as the sole possession of either management or labor. Instead, it must be defined as a negotiated relationship between people. In ignoring this relationship, managers downplay their dependence on staff and use power coercively and destructively (Knights
The essential point is that power or legitimate authority has two sides: a dominating side and a participatory side. Authority in its most meaningful form recognizes the need for legitimate bargaining, hence transforms covert resistance into overt and legitimate opposition. Thus, the negative and destructive secondary latent effects of denying subordination can be seen in a more rational way — conflict may be organized, managed, and dealt with through bargaining or compromise.

This view is compatible with humanistic collaborative clinical sociological interventions, which call for enlarging the common interests and values of organizational members at all levels. Burke (1982:134) states the issue in more practical terms for clinical sociologists and humanistically oriented consultants: "The consultant should help the client empower his or her subordinates so that their energy can be channeled toward team and organizational achievements rather than toward passive hostility, inappropriate competitiveness and an overdependence on rules . . . or feelings of powerlessness." Burke is one contemporary OD consultant and researcher who sees the need for consultants to understand the role of power in effectively managed organizations. Woodworth and Nelson (1979:21), however, provide a more radical assessment of OD consultants for perpetuating a conservative view of dominating power:

In short, we see most OD interventions as consisting of minor adjustments in the organization's culture — adjustments aimed at ensuring the goal of continuity and power structure of the system. As often as not, intervention by a change agent is called for by someone in the firm's upper echelon who is trying to create a power base larger than those of his rivals in the firm. Thus for all the consultant does, he seldom steps out of the bounds establishing the politics of the system.

The contingent management of change processes appears to make little difference in the lives of many workers (Woodworth and Nelson 1979). OD techniques and programs have often perpetuated the existence of passive, disillusioned, uninvolved, and powerless employees. Clinical sociology has yet to determine whether its value base and ethical stance are consistent with assisting management in making changes of greater benefit to those already in power at the expense of the relatively powerless.

A fourth issue is the complexity and turbulence of external events that influence OD efforts. Those who are interested in organizational change, development, and effectiveness need to recognize that in many organizational settings change occurs via processes other than OD. It is apparent from even a cursory glance at the literature (Argyris 1980; Kets de Vries 1980; Pfeiffer and
Jones 1976) that the romantic lure of organizational development and planned change has recently been eroded by numerous external events: selective deregulation, high interest rates, tight money, inflation, and other scarce resources. The initial evangelical heat of OD "true believers" (Harvey 1974) has cooled in the flood of constraints of a highly turbulent world. How these external factors affect organizations trying to change in humanistic and effective directions is an essential part of organizational analysis. For example, dramatic internal change often results from external shifts in organizational power, competition, and new technology, from regional shifts in money markets and investment, and from adjustment to tight money, computerized information, robotics, and global interdependencies.

**Implications for Clinical Sociology**

This brief review of the problems of organizational development highlights issues which clinical sociologists must consider as they work in this area. There are three major issues: selecting the proper unit of analysis; the need to understand and use concepts of power, culture, and authority; understanding the learning constraints that inhibit interaction.

1. **Units of Analysis.** Clinical sociological intervention in organizations may be at any level. Should it downplay macro-level behavioral interventions, or integrate them into micro strategies? Research in organizational development suggests the increasing importance of macro-level changes, and interventions at this level are increasingly visible in business school curricula (Miles 1980). A systems theory perspective allows the clinical sociologist to operate at a variety of levels, drawing connections among them.

2. **Concepts.** Culture and power are important concepts in understanding the dynamics of organizational change. Many clinical sociologists (Glass 1979:516-18; Fritz 1979:586; Hurvitz 1979:574) have expressed concern about the traditional "victim blaming" ideology implicit in ignoring system-wide structural and contextual barriers. The clinical model is built upon a humanistic and holistic recognition of the individual operating within social system constraints. Mills's contention that personal problems are really public and structural issues needs more rigorous articulation.

Thurow (1980:110-25) provides a "zero-sum" model of political-economic systems that might be useful for clinical sociologists studying organizations. In a zero-sum situation, which requires bargaining over scarce resources, there will always be winners and losers. Knowledge of the dynamics of power and bargaining requires the creation of social structures in which power and control are shared in ways that benefit workers' initiative and
democratize loss allocation. Institutional leaders cannot expect that asking for economic progress and security for themselves will protect others from loss. Only by addressing values of justice, fairness, and equity can living in zero-sum organizations allow people to work together to create more viable enterprises.

Hart and Scott (1979:13-80) framed this question in the language of values that make up the "organizational imperative" in America (for example, excessive specialization, planning, paternalism, dispensability, and obedience). The issue becomes one of transforming these values into a new vision of human nature and the cultural values implicit in the humanistic imperative (innate humanistic limits, indispensability, community, spontaneity, voluntarism). As our society moves from individualistic to organizational values, can OD consultants/clinical sociologists provide substantial help to individual clients by fine tuning or tinkering? Is "renewal" or "effectiveness" achieved merely by propping up the organizational imperative? The answer seems bleak if we look at large-scale bureaucracies, especially in comparison to the Japanese model.

3. Learning Constraints. Change to a more humanistic model also involves the identification and explication of the learning constraints under which individuals and organizations operate. For true organizational change to occur, the nature of organizational errors, including manipulation of personal relationships and social structural arrangements, must be identified and corrected. Such change involves recognition of metatheoretical thinking and the development of creative interventions to modify fundamental cultural values and organizational norms, policies, and procedures that create win-lose games or zero-sum situations. Clinical sociologists can address the potential dangers of focusing too heavily on either micro-level behavior or single-loop strategies of learning because these often fail to throw fundamental norms and structures into analytical relief.

The Impact of the Japanese Experience

Human relations productivity and work measurement specialists sometimes concentrate erroneously on the quantitative aspects of work, ignoring the qualitative. For example, the workers at General Motors' Lordstown, Ohio, Vega Plant resented management's decision to utilize the latest technology in order to speed up assembly line production. Assuming that the workers desired only higher pay, bonuses, and other extrinsic rewards, management ignored intrinsic rewards and worker involvement in structuring the production process. The quality of Vegas dropped quickly, and the line was down constantly because workers sabotaged the technical system. In contrast, Aber-
nathy (1983:78-79) summarizes the key differences achieved through integrating the technical (quantitative) and social/cultural (qualitative) systems in Japanese industry:

In Japan, the work force is viewed as an integrated part of the manufacturing system, as something to be carefully nurtured. . . . Nor, for that matter, are the Japanese uniformly successful. But the differences between operating in the two countries are real, not the fabrication of some human resource consultant. Americans buy and sell labor; the Japanese build a productive process around it. . . . Again, what the Japanese have deliberately done is treat their work force as a key point of competitive leverage. This has its costs—workers face the same grueling pressure as managers do—but extraordinary benefits as well.

Abernathy (1983:78) notes in his comparison of Japanese and American factories that the “status symbols of management often get in the way of first-class operations, that narrowly-defined jobs waste valuable human talent, and that adversarial relationships between workers and managers need not be an inescapable fact of life.” On the other hand, one of the costs of the Japanese system is a lack of social, geographic, or occupational mobility. The Japanese worker is tied to the employer in many ways that would not be tolerated by American workers: greater involvement in the work experience may come at the cost of other areas of personal and social freedom. The critical question remains how technical and sociocultural systems are integrated to ensure quality work, efficient use of capital and other resources, and high worker satisfaction.

The difference between the Japanese and American systems lies in the presence or absence of cultural climate and social organization factors that nurture involvement, creative problem solving, and authentic teamwork. The success of quality circles and similar programs depends on the existence of strategic, innovative, “thinking” organizations. Problems and pitfalls exist for all organizations in our competitive world — even for the Japanese. Their experience reflects the extent to which they have incorporated the environmental turbulence of market competition into their integrated organizational systems.

**Conclusion**

Neither OD specialists nor managers cause the greatest proportion of organizational change. Clinical sociologists can create interdisciplinary OD teams that confront both internal and external behavioral and structural obstacles to constructive change. The strong tradition of sociological theory
and research in organizational behavior provides a solid base from which to conduct a multi-level systems-oriented OD practice.

Specifically, the sociologist has an advantage in engaging in organizational development because of training in research design and methods, a broad awareness of systems and structural issues, and sensitivity to cultural phenomena such as family trends, workplace values, and ethnic, racial, or sex-role stereotypes. Because of their view regarding the situational basis of personal problems, clinical sociologists can also design and adapt micro-level interventions; acquisition of small-group theory and insights strengthens practice at this level.

These reflections are intended to increase discussion and analysis within the slowly consolidating networks of clinical sociologists, OD specialists, and applied behavioral scientists about the meaning and strategic relevance of organizational development for a changing world.

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Doing Sociology with the Design Professions

Bernie Jones

ABSTRACT

This paper builds on twin assumptions that human behavior and physical places influence one another, and that design and planning should therefore be sensitive to the users of the built environment. Sociologists have a key role to play in shaping the built environment: they can bring the users' concerns to the design and planning process. Predesign research, research on the design process, and post-occupancy evaluation research are among the tools utilized by clinical sociologists working with environmental and design issues. Criteria to employ in selecting design research methods are identified and nine specific methods are ranked on those criteria and explained.

Introduction

Winston Churchill is reported to have said, "We shape our buildings, and then they shape us." Sociologists have a vital role to play in that shaping process. This paper reviews the nature of and rationale for sociological practice with the design professions. Over the last two decades the design and planning professions have gone through an internal revolution as they introduced the systematic utilization of social and behavioral scientists into their work. Starting in the late 1960s, the author began consulting with designers and planners on such projects as comprehensive community plans, low-income housing developments, child-care facilities, educational facilities, and neighborhood parks.¹

Working as a consultant to architects, planners, and users requires the clinical sociologist to modify standard research methods and techniques because many of them do not work effectively in field settings. A diagnostic approach to the planning process, incorporating analysis of the consequences of specific design decisions, marks the contribution of the clinical sociologist.
who is able to adapt research methods to the immediate needs of the situation, provide meaningful feedback to clients, and help facilitate constructive interaction among various participants in the process.

Rationale

As early as the 1920s, Park (1951) acknowledged that there is a rhyme and reason to the way people use the physical terrain of the city. The Chicago school of ecological sociology that emerged from his seminal work was very much attuned to the physical environment of the city. Significant early studies include McKenzie's (1923) observation of the urban milieu, Shaw's (1929) studies of delinquency in the city, and Wirth's (1928) classic study of the urban ghetto. Later, others moved to the micro level, studying how people interact with their immediate environment: Festinger, Schacter, and Back (1950), Hall (1966), Barker (1951, 1968; Barker and Gump 1964), and Fried (1972).

Interest in the interactive relationship between human behavior and physical settings is reflected in professional societies and journals devoted to the subject (e.g., the Environmental Design Research Association, Environment and Behavior) and courses on such topics as social factors in urban design. Practitioners in these areas, variously calling themselves environmental sociologists, environmental psychologists, social psychologists, or design researchers, concur that physical settings and our ideas about them affect social interaction, and vice versa.

A corollary aspect of this reciprocal relationship between behavior and environment is that all physical designs emerge from social processes. Decision-making activities involve intensive interaction among designers, planners, architects, and others engaged in the design/planning process. Figure 1 shows the scope of concerns associated with the various design professionals involved. In addition, government officials, lending institutions, building contractors, landowners, and users play a variety of significant roles in shaping the process. The multiplicity of roles involved in the process makes it particularly amenable to sociological practice informed by knowledge of role expectations, cultural and occupational values, theories of community and urban ecology, and social research techniques.

The Sociological View of Design and Planning

Basically, design is a value-added process. Borrowed from economics, this term means that as raw material becomes a shaped, finished product, its value increases each step of the way. At the same time, however, the range of final forms the raw material can take grows increasingly narrow as the process nears completion. The design process is similar. The architect or planner begins with
an idea; as design decisions are made about it, the idea becomes more real and more valuable, but the range of final designs contracts. Architects, for instance, start with a program, which is a verbal outline of needs the building or space should satisfy. During conceptual design, schematic or general design ideas are formulated, and the range of outcomes starts to narrow. Accepted conceptual designs are fleshed out during design development, further locking the designer into an evolving final form. During the construction documents phase, the final form is dictated in a set of instructions to the building contractor. Few significant changes are made during the last stage, construction supervision. Other designers and planners follow similar stages of work.

Figure 1
Concerns of the Design Professions

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<th>Design Elements</th>
<th>Furniture Designer</th>
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This aspect of design and planning holds import for the sociologist because it suggests that involvement of potential users of a facility in the design process must occur during the very first stage. Once the design process gets under way, the possibilities for alterations, based on human needs expressed either directly by the users or indirectly by a sociologist, quickly shrink. In addition, the further along the design process, the more specific and technical the work becomes, making it harder for the layperson to contribute meaningfully.

Another sociologically relevant perspective on the design/planning process concerns the degree of role specialization involved in it. The built environment has not always been the product of people called architects, planners, landscape architects, and the like. "Architecture without architects" has occurred throughout much of history (Rudofsky 1964). Rapoport (1969) discusses the way that people in earlier times were able to plan, design, and build living environments that were well suited to their needs. No one stood between the user and the final product, which enabled the user to make sure that the building reflected his or her personal needs and culture.
With industrialization, bureaucratization, and specialization, however, the proliferation and professionalization of roles in the design process has expanded significantly (see Figure 2). All the activities current specialists handle were once the responsibility of the one-person or one-family designer-builders of earlier times.

**Figure 2**

Specialization of Roles in the Design Process

As the cast of characters grows, the role of the ultimate user is proportionately reduced. Furthermore, the technical skills of other participants easily overshadow user contributions. As the number and variety of roles in the design process multiply, concern for user needs diminishes in its centrality. Competing considerations include the traditions of each professional, profit motives, competition and friction between professions, government regulations, and funding problems. However important these considerations may be to the various participants, they are not necessarily related to meeting the user’s unique needs through good design.

**The Politics of Design and Planning**

Perhaps the most significant tangential considerations are political ones. I am defining “political” in the broadest sociological sense of decision making and the use of power. Design process decisions about whether something should be
built, where it should be built, for whom it should be designed, are intensely political decisions often involving power struggles over such issues as zoning, land use, eminent domain, displacement, gentrification, accessibility to special populations, integration, segregation, social impact, and environmental protection.

If the design/planning process is political, entering into it constitutes taking sides, responding to an audience, and rendering oneself accountable to some party: playing the role of artist for a wealthy patron, methodologist for professional colleagues, or uncritical procurer for parties financing a project. Although all focus on an end product (judged in terms of cost effectiveness, artistic merit, or “monument value”), and all are to some extent accountable to a fee-paying client who has the power to make choices and pay for their realization, the products of these various roles differ. The artist may produce luxury homes; the methodologist “significant architectural statements”; and the procurer may produce oppressive, alienating office environments, prison-like public housing, or may threaten neighborhoods.

On the other hand, a designer may be equally concerned with the process of decision making and the impact of certain decisions on the social context of the site and its immediate environs. This approach emphasizes accountability to those who will be directly affected by the design outcome, as well as to those who pay the fee (they are not always synonymous). In this case, the designer may serve as a social change agent whose audience is composed of the potential users and/or those people most directly affected by the designs. The designer joins in a cooperative, working relationship with the audience to bring about some improvement defined positively by the community in question.

Depending on the self-image of the designer or planner, he or she will be involved either in demystifying and democratizing the process, or in perpetuating the mystery of design and preserving a monopolistic control over the built environment. The role of the clinical sociologist is in improving communication between user and professional specialists, democratizing the decision-making process, and in defining the impact of specific plans on the community surrounding a site.

**Approaches and Methods in Environmental Sociology**

**Varieties of Practice**

Practicing sociologists who refer to themselves as environmental sociologists or design researchers work at several levels, defined largely in terms of when during the design process they intervene. (I am excluding here pure research on person-environment relations, and focusing on applied work with design and planning professionals.)
1. Predesign Research. In general, the most frequently occurring form of design research obtains information about potential users that will aid the designer or planner in turning out a product sensitive to user needs. The sociologist plays a translator role, interpreting the language of layperson and design professional to one another. The sociological expertise called for is in locating and communicating with the potential users, asking appropriate questions about their needs, or observing their life styles, then translating that information into terms the designer/planner can comprehend and utilize. For instance, one of my projects involved articulating the child-rearing practices of a low-income population to the architect so that he could design a culturally sensitive neighborhood child-care center. Another contract entailed translating student and faculty ideas regarding a new community college to the architects. The challenge was to communicate to the professionals various design concerns shared by the users (size, shape, color, safety, style, spirit, function) regarding particular spaces, buildings, and landscape.

2. Research on the Design Process. Much less common is sociological research on the process itself. On the community college project, I was asked to monitor design team and user interactions, give the designers feedback about the effectiveness of their work, and identify the most productive interaction modes.

3. Postoccupancy Evaluation. An increasingly popular form of design research consists of evaluating a finished, occupied, and utilized facility or space. The object is to determine whether it is working from the perspective of users. This represents a significant shift in the profession of design in which evaluation has tended to be based on visual and aesthetic factors, awards are often given before structures are built, and user satisfaction has been an afterthought at best.

   In the postoccupancy evaluation of low-income housing, for example, I found residents’ concerns focused, first, on functional aspects of the project (why a certain feature was omitted, whether the paint was washable, etc.); second, on sociological implications of design (issues of privacy or the image of the project in the surrounding neighborhood); and, third, on aesthetics (shape, color, line, and form). This is in marked contrast to the criteria often used in making professional awards.

   The role of the clinical sociologist is in generating preoccupancy data, translating the needs of the user and the surrounding community to the design professionals and planners, facilitating interaction between them, democratizing the decision-making process, and evaluating the outcomes.
Specific Methods

When doing any kind of sociological research, the practitioner has to select carefully the methods best suited to the task. Determining the best methods for design process research depends on analyses of such factors as the ease of locating users, the ease of gaining access to them, their willingness to cooperate, educational level and life styles, frequency with which they have been previously studied, timing and costs of the study, and willingness of the designer/planner client to allow research and respond to findings as presented. Data gathering on such projects is most successful when the methods allow: (1) the greatest number of users to make some contribution; (2) stimulation of one person's thinking by another's to produce a rich flow of ideas; (3) open-ended discussion rather than forced, restrictive choices; (4) input from users before preliminary designs are completed, rather than reaction to designs already generated; (5) exploration of what should be and what could be, rather than rehashing of what is or has been; (6) continual participation throughout the design process, rather than a one-shot chance to make input; (7) direct input by users, rather than solely through the clinical sociologist.

Sociological research on design/planning projects, like other sociological research, takes one of two forms: asking people about their behavior or observing their behavior. Both Michelson (1975) and Zeisel (1981) describe various methods in detail and illustrate their use. The following are methods I have used, ranked roughly from the least effective to the most effective in terms of the criteria listed above.

1. **Reactor Panel.** In this method, a small but representative sample of intended users reacts to designs or plans in various stages of completion. This approach is inexpensive and quick but is limited by the small sample. In addition, even sketchy designs and plans rendered by professionals can intimidate the layperson into a reluctance to criticize. I have used this approach in gathering data from users of married student housing, but only in combination with other methods.

2. **Observation of Existing Facilities or Sites.** This method yields indirect data in the sense that the researcher observes users in a site similar to the one to be designed, but he or she does not interact with them directly. Although this method can be time efficient, the major drawback is that patterns of current usage and design dominate, as if culture were not dynamic. Direct observation can be done with the naked eye, or via photography, film, or videotape. An excellent example is Whyte's study of the use of urban open space (1980).

3. **Questionnaires.** While this time-honored social science tool allows the practitioner to tap a large sample of users, one cannot possibly anticipate every
design consideration; thus the one-shot nature of questionnaires becomes a serious drawback. An additional problem is the inability most people have to be very articulate about their design preferences. The method does have greater applicability for less design-oriented, more planning-oriented projects, where the task might be to establish general goals for a comprehensive community plan.

4. **Joint Tour of Existing or Proposed Facility or Site.** This involves users, the design team, and the sociologists all going through facilities or sites, conversing along the way. It is especially good for stimulating questions by the design team or the sociologist for the user. On a married student housing project, such a tour of several existing student housing developments generated helpful comparisons and the pinpointing of many good and bad design features.

5. **Individual Interviews.** Formal or conversational open-ended interviews with users start to yield good results, but lack the interrespondent stimulation that some other methods allow. I found this approach useful in some neighborhoods where residents could not be brought together easily, or at a community college where students’ time was limited.

6. **Public Meetings.** A great deal of interrespondent stimulation occurs in large public meetings as ideas are bounced back and forth. However, the size of the group may intimidate the shy, retiring person and spur on the already vocal person. I concluded after using neighborhood meetings during an urban renewal planning study that they are better suited for the discussion of broad policy issues as opposed to specific design ideas.

7. **Small Meetings.** These meetings usually afford the same rich exchange of ideas as the larger ones, and have the added advantage of allowing more people to participate. In evaluating low-income housing, for example, I found small house meetings useful for producing lively discussion.

8. **Design Workshops.** An even better version of the small meeting, the design workshop allows design professionals and sociologists, using models, drawings, maps, floor plans, games of trade-off, and so on, to try to elicit ideas and put them into graphic form. Users can then see their ideas actualized, elaborate on them, and revise them. This affords an active role for the user. On the married student project, users arranged styrofoam blocks on a topographic map of the site to show their preferred site plan.

9. **Communications-Response Cafeteria.** Each of the data-gathering approaches outlined above has strengths and weaknesses; sometimes a combina-
tion of them can be used effectively. The combination approach is built on some assumptions about the social research process as a communications act. First, the burden of good communications rests upon the party wanting to communicate in the first place (for our purposes, the researcher). Second, that burden should also be upon the party with the greater resources for communications (again, the researcher). Third, and finally, good data cannot flow through a poor researcher/respondent relationship. I interpret these assumptions, then, to mean that the sociologist must ensure that no one who wants to give input is shut out simply by the choice of information-gathering methods. These assumptions lead to a basic hypothesis: the more heterogeneous the population of users, the more varied the types of data-gathering approaches will be necessary for greatest and most creative input.

For example, on a feasibility study for an urban renewal project, my team offered residents of the area a number of ways for participating and responding. A neighborhood storefront was established where residents could drop in, talk informally, review maps and drawings, and offer their ideas. Telephone inquiries were turned into semistructured interviews. Three field workers spent time in the neighborhood, frequenting natural congregating places and talking with people about the project. Short questionnaires were left at the counters of neighborhood shops; on several days tables were placed in large supermarkets, complete with staff, maps, photographs, and questionnaires. Two dozen community meetings of different sizes were held throughout the study area. Different demographic groups (young, old, renters, owners, etc.) gravitated to different channels of communication, thus confirming the team’s implicit hypothesis.

In a second study utilizing this combined approach, the task was to obtain data from faculty and students at an existing community college about the design of a proposed new campus. The fact that only two weeks were allowed for research made a powerful argument for opening as many communication channels as possible. The team set up a space in the existing student lounge featuring a central table where informal conversations about the project were taped anonymously and with permission. A continuous slide show about the site, complete with music, stimulated ideas which could be recorded on long sheets of paper at the table or on large newsprint pads hung on the walls. A site planning game, consisting of a topographic map, various small objects to use as buildings, and appropriate labels, allowed users to visualize their ideas for the new campus. A sign-up list encouraged people to accompany us on a walking tour of the building site. Large sheets of paper asking “what would you like the new campus to be like?” were hung in conspicuous places throughout the existing campus.
Conclusion

The results of these approaches were summarized and used to generate a list of specific concerns and recommendations which were submitted for response to the architects and planners. This process stimulated an ongoing exchange of ideas beginning early enough in the design process to make a realistic and meaningful impact on the decision making. In some instances the clinical sociologist's role will end at the point of diagnostically evaluating the potential impact of the plan on users, and tailoring research methods to the characteristics of users. However, the role may continue throughout the planning and revising stage into evaluation. In either case, the clinical sociologist performs an important role in reducing the distance between user and design product.

NOTES

1. In the category of designers and planners I am including interior designers, architects, landscape architects, urban designers, and planners, each of whom deals with different but overlapping parts of the built environment.

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Clinical Sociological Perspectives on Social Impacts: From Assessment to Management

Kevin Preister and James A. Kent

ABSTRACT

The social impact assessment (SIA) field is moving into a critical and central position in resource decision making in our society. Initially conceived as part of the environmental impact statement (EIS) process, SIA is beginning to be recognized as having dimensions far beyond its early scope. This article focuses on the extension of SIA work into the area of social impact management. Current trends in the SIA field leading to the emphasis on management are reviewed, followed by a discussion of the issue-centered approach to SIA. A discussion of decentralization trends sets the stage for understanding the emerging demand for impact management services. A definition of and rationale for social impact management are provided, and four principles of social impact management are described. Finally, the process by which impact management systems are developed is discussed through selected examples.

Since the passage of the National Environmental Policy Act (NEPA) in the 1970s, social impact assessment (SIA) has claimed increasing attention in the overall environmental assessment process. This has occurred, in part, because of public demand. As we move through the 1980s, people are more aware of the social and cultural effects of resource development on their lives and they are insisting on early participation in decisions. The courts, moreover, have been interpreting NEPA in such a way as to give the social components of impact statements greater weight.

The regulations that direct the EIS process have also changed. Revised environmental quality regulations call for documents that use jargon-free language, are shorter, and aid in the decision-making process. In addition, the mitigation phase of the EIS process is receiving greater attention. Officials not only want to know what impacts are predicted, but also insist that options for dealing with them be developed and early mitigation agreements be reached.
In short, the EIS is moving away from being a declaratory document which merely discloses impacts to becoming a management tool which citizens, industry, and government can use to reach decisions about the future.

SIAs that are performed within the legally prescribed EIS arena often do not lend themselves to effective management of impacts or socially responsive decisions. Even well-conceived, locally grounded mitigations will not be useful unless all parties have been actively involved in developing the mitigations. The dialogue between citizens, government agencies, and private interests that would promote mitigation agreements is frequently not part of the formal process. Also, the involvement of the social scientist often ends as the impact reports are submitted, so these additional resources are not available to residents and officials for carrying out the mitigation phase. However, when social scientists are able to stay involved, the first steps in the management of impact have been made. Social impact management (SIM) is a people-centered, ongoing decision-making process designed to identify, evaluate, respond to, and monitor the public issues arising from major industrial and government activities. The role of the clinical sociologist is viewed here as spanning both social assessment and social impact management.

**Clinical Sociology and Social Impact Management**

During the past fifteen years, the authors have been working as social scientists in the growing fields of social impact assessment and management, organizing and documenting clinical sociological systems, mapping the real geographic units within which people function in an ecological state. Clinical sociologists are best suited to address the profound shift in our society from a vertical (power elite-based) to a horizontal (community-based) decision-making system. Once outside the influence of the vertical system, one can see that clinical sociology emphasizes the ecological process working with rhythms and multilevels of interaction. The ecological focus replaces the mechanistic and hierarchical focus of past sociological concentration. We have assembled many of the tools needed to understand and function in this new horizontal age. Social impact management represents a statement on how our tools are used and offers a model for intervention at the community and organizational levels.

**Four Principles of Social Impact Management**

Intervention in social impact management systems and the training of management groups to implement these systems are guided by a series of four principles rooted in social ecological and critical approaches in sociology:
1. Individual power is essential for maintaining the productivity of the human environment.

2. Human-geographic boundaries are natural management boundaries.

3. Horizontal social networks form the structure by which communities sustain themselves.

4. Direct contact with citizens is necessary for managers seeking to understand and respond to public issues.

**Principle 1: Individual power is essential for maintaining the productivity of the human environment.** Perhaps the most fundamental principle of all is the singular importance of the individual person. Power is the ability of the individual to understand, participate in, predict, and control his or her environment. Individual power is essential to maintain a vigorous community and a healthy relationship between citizens, industry, and government.

If individual power is not maintained, people become demoralized and sooner or later will resist. Sometimes resistance takes place openly, as in the case of protest demonstrations or labor strikes, but more often it takes place in such subtle and indirect forms as alcoholism, absenteeism, malingering, transience, crime, and similar acts that erode the ability of individuals and communities to sustain themselves. It is assumed here that the social and financial costs of powerlessness are far greater than the costs of cultivating citizen empowerment. This holds regardless of whether it is citizens, business, or government which ultimately suffer the costs.

The key to addressing effectively the consequences of powerlessness lies in the facilitation of individual power through citizen participation, which includes the following components:

- Citizens are able to understand the full meaning of the social and cultural implications of proposed changes in their environment.
- Citizens share in the decision-making processes which determine what will happen to them, their families, friends, and neighbors, and to the common environment they share.
- Citizens assume their share of responsibility for carrying out the decisions they have helped to make in the interests of the greatest good for all.
- Citizens have continuing opportunities to track the resolution of their issues through the planning and implementation process.

Citizen participation is essential for effective management since managers will inevitably experience conflicts with various publics over proposed changes. Significantly, it does not rest solely on occasional public hearings that
often fail to build upon traditional modes of public interaction, are scheduled inconveniently for many people, and are not conducted in comfortable settings.

**Principle 2: Human-geographic boundaries are natural management boundaries.** Environmental law and the social ecology tradition emphasize the concept that human and physical resources are ecologically unified. When this basic principle is combined with the previous principle of individual power through citizen participation, a new form of *human resource mapping* emerges based upon natural geographic patterns of cultural values, networks, and daily routines. Social boundaries become administrative units for program implementation and decision making, as has been done by Region 2 of the Forest Service. Boundaries based on social criteria are natural ways to group issues for managerial attention.

Natural boundaries of actual human communities rarely coincide with arbitrary administrative districts such as counties or regional government units. The mitigation efforts of large-scale development projects, for example, are difficult to administer at local and regional levels when natural boundaries are not considered. An example is the "jurisdictional mismatch" occurring on the Western Slope of Colorado; problems associated with political jurisdictions prevent oil-shale-impact dollars from reaching targets where they are most needed.

**Principle 3. Horizontal social networks form the structure by which communities sustain themselves.** A crucial distinction is made between the *vertical structures* of formal authority relations and the *horizontal structures* of voluntary cooperation that pattern day-to-day living and survival for most people.

While vertical structures are instrumental and necessary in a complex society, planning and management activities that rely solely on the "official" version of reality as defined by lawmakers, bureaucrats, and corporate representatives of vertical structures run the risk of misrepresenting the public for whom they hope to speak and of contributing to "government by ambush," disruption, and surprise tactics. Public outcry at the eleventh hour of implementing a decision is a sign that vertical structures have worked more effectively than horizontal structures.

The changes currently occurring in American society are far-reaching and are reflected in the growth and development of the SIA field. A profound influence on the institutions of society is the shift from a centralized to a decentralized society and the meaning of this change on centralist-trained thinkers. Increasing diversity and self-determination are affecting all aspects of life. Centralized decision making is losing ground; companies and institutions that are not responsive to this change are finding it increasingly difficult to function effectively.
To adapt to the fundamental and profound changes now gathering momentum, some business leaders and public officials are becoming more flexible, humanistic, accommodating, and socially responsive. In business environments, the dictates of the marketplace are forcing companies to address the social consequences of their actions. Similarly, in a democratic society where public participation is increasingly being mandated by law and official regulations, government offices and agencies are becoming legally liable when they have not responded to the full range of public issues related to their activities.

This shift means that increasingly it is the general citizenry who are the real decision makers. Successful politicians and industrial leaders are those who can communicate with people and expedite decisions in a way that is sensitive to diversity and leaves control in the hands of citizens.

The social changes described above have led to an increased demand from industry and government for training and consultation services for the management of impacts and the public issues created by impacts. These are services that are not required by law and, while applicable to an EIS process, are not limited by it. However, they have become increasingly necessary in carrying out a resource development project. Projects that do not have social impact management components risk conflict and costly failure.

Management activities and decisions that are described to be responsive to the public must be tailored to the daily routines of citizens. For this reason, effective management depends on the ability of managers to understand and work with horizontal systems; no longer is it sufficient, for example, to hold public meetings with time and place determined by the managers. The horizontal structure indicates the functional groupings and boundaries people use in their everyday activities.

The term *networks* is used to describe the informal social relationships of daily life. These are patterns of communicating, caretaking, gathering, and interpersonal support around common interests which reflect and help shape values and perceptions people hold regarding their lives and their environment. The identification of networks is an integral part of the development of social impact management programs since networks are the vehicle through which people in the horizontal system express and manage their issues.

**Principle 4. Direct contact with citizens is necessary for managers seeking to understand and respond to public issues.** Social impact management is a process and not a product. It is mediated in face-to-face relations; its successful application therefore depends on the personal commitment and skills of specific individuals. For this reason, the importance of experiential learning through direct contact is stressed in the training of different management groups. Managers and their staffs, or professionals under contract to perform
such services for managers, must directly enter the communities in which they operate to verify their understanding of public issues and to assure broad-based contact. As with any human-service professionals, managers who make decisions about people must continually reassess their own cultural biases, which may distort true understanding. The clinical sociologist can facilitate this values clarification and the direct contact which social impact management systems are designed to provide.

Planning and Impact Management

Since social impact management begins with assessment and includes other planning functions, the distinction between synoptic and transactional planning is an important one. Hudson (1979) notes that the most dominant form of planning is called synoptic planning, which involves the process of goal-setting, identification of policy alternatives, evaluation of alternatives, and implementation of decision. It involves looking at problems using conceptual or mathematical models, and is heavily reliant on numbers and quantitative analysis. Its primary focus is on the development of "plans," technical relationships, and objective realities — to the exclusion of subjective or emotional discussions which arise from divergent perceptions of problems being addressed.

In contrast, transactive planning is never carried out with respect to anonymous beneficiaries, but requires face-to-face contact with the people affected by decisions. This approach to planning "consists less of field surveys and data analyses, and more of interpersonal dialogue marked by a process of mutual learning." When following such an approach, "plans are evaluated not merely in terms of what they do for people through delivery of services, but in terms of the plans' effect on people — on their dignity and sense of effectiveness, their values and behavior, their capacity for growth through cooperation, their spirit of generosity" (Hudson 1979:389). Transactive planning is compatible with the values and perspectives common to clinical sociologists.

It can be seen that synoptic planning may be entirely appropriate for management of the "internal" environment of a business organization or government unit. However, management of the "external" — or social — environment is the appropriate arena for transactive planning. Care must be taken that planning activities that are designed to understand and respond to the external environment are not based on the cultural biases of the managers or the professional under contract to managers. Principles used in social impact management that are designed to prevent this occurrence are discussed later.
The Issue-Centered Approach to SIA

An issue-centered approach to SIA, based on horizontal network focus and a commitment to transactive planning, has been developed to promote citizen involvement in the EIS process and ownership of its outcomes. Efforts are made to maximize people's understanding of the proposed actions and to stimulate their interests and active involvement in the assessment and eventual management of expected impacts. Several points distinguish an issue-centered SIA from more traditional approaches. Throughout, the use of the full panoply of sociological research methods, from participation observation to survey research, is crucial for effective data gathering.

1. Issues are identified using indigenous language. Field workers live in the study area and have routine contact with the informal networks of people who make up local neighborhoods and communities. The network approach is an effective way to get information about the full range of interests and issues people have in relation to the proposed project, and to facilitate participation of citizens in the decision-making process. Relating with people in settings that are natural to them improves the quality of information received and facilitates involvement. Also, the need for attitude surveys and other statistical approaches is reduced since a thorough, systematic, and legally defensible understanding of issues is possible with the network approach. Issues are identified according to NEPA regulations for accuracy, prevalence, intensity, and duration.

2. Public issues and management concerns are the driving forces for the collection of social and economic data. Concerns of responsible government agencies are also identified, revealing possible long-term effects that can be included in the assessment process. Once qualitative data are generated by the field team through participant observation and informal contacts with citizens and networks, quantitative data are generated (if possible) to substantiate and more fully document the scope of the potential impacts. Citizens and local officials thus participate in the development of the assessment through a discussion of their issues and concerns.

3. The analysis of the proposed development uses public issues and management concerns. The heart of the assessment includes how issues and concerns are affected by different levels of development (including no action), the project as proposed, and other alternatives that are identified through the course of the review. In this way, local residents and government officials receive direct feedback about how their issues or concerns are affected; they can then act in their own self-interest.
4. Citizens are able to track their issues throughout the decision-making process. Project assessment questions are derived from public issues and management concerns. Social and economic data are then collected to answer these questions regarding the project. In addition, possible opportunities to resolve the issues or concerns are identified by citizens and agencies at the local, state, and federal levels. This information is relayed to people in the community via informal contact, published reports, and media coverage. The series of documents produced through the course of the EIS becomes part of the decision-making record. Not only is this a clear benefit to citizens, but it fulfills the legal requirement that agencies institute a mechanism enabling citizens to "track" their issues.

5. Mitigations are grounded in local conditions. Ongoing contact with people in the local area as to expected impacts, the degree to which their issues are being addressed, and critical points in the decision timeline are vital components of an issue-centered SIA approach. As a result, possible mitigation measures that could be taken to resolve issues and minimize impacts are identified and developed by citizens and officials, rather than emanating from outside "experts." The appropriate individuals, citizen groups, or agencies with ability to respond to the issue are identified. In this way, people have a clear idea of whom they should approach to obtain action. A local commitment to implement or sustain mitigation measures therefore develops in support of decision makers who are attempting to use the SIA as a management tool.

The Adam's Rib Case

The approach to SIA was recently used to review a proposal for a major ski development, Adam's Rib Recreational Ski Area, 40 miles west of Vail, Colorado. The project had been planned for over seven years, but was so controversial that the first review ended in disarray and without a decision. While the Forest Service eventually approved a scaled-down version of the project, the county rejected it, citing inconsistencies with its Master Plan in a number of areas.

The significance of the decision, for local residents as well as for SIA professionals, is the process of issue resolution that helped determine the final decision. The proponent, government officials, and citizens had good information about public issues and management concern; the proponent chose to address many of them during the course of the review. However, significant impacts remained unaddressed, including high growth rates during the construction period and an inadequate road for projected traffic demands. In view of the high financial costs of resolving these and other issues, the proponent chose not to address them. The Adam's Rib decision, although not a final
one, was a community choice because people stayed involved throughout the process and consistently managed their issues. In the few weeks prior to the final hearings, field team members assisted citizens, business people, and the developer to prepare for testimony by helping them to clarify their issues, to understand the impacts that had been identified, and to apply the laws and regulations pertinent to the decision. Officials at both sets of hearings commended community members on their well-disciplined and well-documented testimony.

The Development of Social Impact Management Systems

The key focus of social impact management is to determine how an existing culture functions, to identify the informal methods of problem solving people use in their routine experience, and to clarify how decisions are arrived at and implemented in the community. Once the cultural mechanisms are identified, then specific communication links into that culture can be established so that it can efficiently process outsiders and new ways of doing things with minimal confusion and disruption. By tapping into the way a community communicates daily and resolves its problems, strategies to resolve issues related to social impacts are assured of being practical and grounded to the social context.

The goal of social impact management is to assist government and industry to externalize management so as to understand the grass-roots issues of the individuals and their affected cultures and communities. Once externalization takes place, the company or agency then organizes its internal operations to fit what they have found.

Figure 1 indicates the six steps involved with the development and implementation of a social impact management system. In practice, the procedures from step to step are considerably more detailed and methodical than outlined. As indicated by the clockwise motion, the process both begins and ends with description in a continuous ongoing loop, which means that it never actually ends as long as the organization keeps the cycle of impact management alive. Methods to organize incoming data in a systematic way are developed with the client. Managerial action or intervention can be taken at any stage of the process when it seems desirable and feasible to do so.

The process for resolving issues and facilitating mitigation agreements occurs in the design and implementation of strategies. Emerging and existing issues are cycled back into the management sequence and addressed as opportunities for creative responses in management practices. A primary intent is to prevent emerging issues from becoming disruptive and to create a climate of mutual trust and open communication. An issue that is resolved early main-
tains the stability and integrity of the management system by preventing costly aberrations in its functioning while fostering stable relationships with the community. An issue that is allowed to become disruptive tends to constrict or eliminate the options of management to deal with it, since it is then often handled by higher levels of authority, media attention, or the courts. A disruptive issue still influences management activities, but usually in ways that are not desired.

**Figure 1**
Steps in the Development and Implementation of a Social Impact Management Process

- **Describing Communities**
  - or areas affected by proposed changes using key social variables and indicators

- **Evaluating Results**
  - and monitoring further developments for changing or unanticipated situations

- **Generating Themes**
  - and topics of broad public interest and concern

- **Identifying Networks**
  - or organized groups and the specific issues they carry

- **Implementing Action**
  - strategies and/or mitigation schedules to resolve public issues

- **Designing Strategies**
  - and implementation tactics through responsive planning

**The Application of Social Impact Management Programs**

The process for the management of social impact outlined in this paper takes many years of ongoing commitment to implement. In recent years, the authors have worked (through FUND — Foundation of Urban Neighborhood Development) with local governments, federal agencies, multinational energy corporations, telecommunication firms, and other clients. Different communities and agencies FUND has worked with are in varying stages of institutionalizing this process. Three examples are offered here.
Honolulu. The most recent and comprehensive example is a series of contracts FUND has had over the last two years with the city and county of Honolulu to develop what is being called a Social Impact Management System (SIMS). Prior to our entry, land-use conflicts had been growing. The dominance of the tourist economy and decline of diversification had limited the ability of citizens to control their future. Growth impacts had reached high levels: six out of nine council members were under recall, development projects were being stopped in their tracks, and the deterioration of neighborhoods was visible daily in crime rates, youth unemployment, and social service demands.

By using the social impact management process described in Figure 1, neighborhood units and public issues were identified and contacts with citizen networks established. This activity led to the development of city ordinances which were drawn up to incorporate social impact guidelines, including a Social Impact Permit, into the city charter. If the city council votes to adopt these measures, Honolulu will be the first municipality in the nation formally to institute social impact guidelines. The process of full development in terms of establishing a long-term culture of involved citizens able to control their destiny will require many more years of intentional effort.

Forest Service. Another example is the Forest Service in Region 2, which is attempting to institutionalize a program called Socially Responsive Management (SRM). After five years of effort, the fine tuning of the program is now in progress and includes such considerations as how to improve regional coordination for resolving issues and how to build personnel incentives for socially responsive management.

The Forest Service has acknowledged the following results from its SRM Program: increased awareness of the social environment of which their organization is a part; a better understanding of the mutual influence between Forest Service activities and local communities has been realized on a practical level; Forest Service personnel have regular contacts with citizen networks to monitor changing interests and to update information on how issues are being addressed; public involvement has been implemented in a way that fulfills legal requirements while providing more useful information than is available from surveys; legal requirements are fulfilled so that citizens are able to “track” their issues throughout the formal planning process.

Upper Eagle Valley. FUND’s most inclusive effort to date has been the town of Minturn and other communities in the Upper Eagle Valley, Colorado. Over the last eight years, FUND has had a series of contracts and grants from the ski industry, the Forest Service, and foundations to assist local communities as they continue their transition from a timber, mining, and railroad economy to one of recreation. A management process was not included in formal govern-
ment or corporation structures, but a culture of involvement and control has been established with the people. The following results have been realized: the small-town character, Hispanic population, and strong family orientation that its residents wanted to protect from the condos and the "eternal vacation" atmosphere of nearby ski areas have been sustained; the first social impact mitigations in the nation to be included in a Forest Service permit included provisions for employee housing and a career conversion program; the stabilization of the local communities required a $5.4 million land purchase from Vail Associates to protect land uses at the entrance to Upper Eagle Valley; the land was deeded to the Forest Service to protect it from development and to provide local recreation opportunities (the closing of the Gilman mine required career conversion efforts to help miners in the transition to a recreation economy); eighteen minority-owned businesses were established and a career conversion program developed; pressure was added to a state-wide effort for a policy on mine closings that would require mitigation efforts.

Conclusion

This paper has presented a clinical sociological approach for responding to the increased demand of industry and government for socially responsive management training and consultation. This approach to social impact assessment and management is applicable for legally required SIAs or for efforts undertaken by industry or government as good management practice. Two professional goals are realized: (1) an issue-centered, comprehensive, scientific, and predictive assessment of social effects; and (2) the professional ethic which demands an accurate reflection of the social reality that leads to increased ability of communities to control their future.

The number of contracts related to social impact prevention and management is growing beyond legal requirements and is likely to continue to grow. Social science professionals who can build cultural bridges in a practical way between different groups in a diverse society will be in high demand. Opportunities for leadership in social impact assessment and management are available for clinical sociologists with training in methodology, community and urban theory, and environmental sociology.

NOTES

1. An earlier version of this paper appeared in Social Impact Assessment Newsletter, Nov./Dec. 1981, C. P. Wolf, editor. Special acknowledgement is due to FUND staff members who have contributed to the conceptual development of the present paper: Linda Bacigalupi, Hugh Gardner, Rick Greiwe, and Bob Gallegos.

2. Power in this sense operates in a manner that draws people together in networks for mutual action but discourages the exercise of power over others. See Kent (1972).
3. See, for example, Toffler (1970); Ferguson (1980); and the works of John Naisbitt, publisher of the Washington, D.C., Trend Report.

4. It is becoming increasingly difficult, incidentally, for federal agencies to get approval for surveys through the Office of Management and Budget, particularly during the Reagan administration.

5. Published reports related to the social and economic impact assessment of the proposed Adam's Rib Recreational Area are available through FUND, Denver, Colorado.

6. In addition to those mentioned here, organizations currently implementing this process include selected forests in Regions 2, 4, 8, and 9 of the U.S. Forest Service; the State of Virginia Division of Forestry; and the Bureau of Forest Development, Philippines.


8. Richard J. Greiwe, FUND's manager of training programs, has prepared four handbooks used in Forest Service SRM training, available through FUND, Denver, Colorado.

9. Publications discussing the recommendations stemming from the Redcliff, Gilman, and Minturn areas (by Jean Bailey and James A. Kent) and on the Upper Eagle Valley (Susan E. Massman, ed.) are available through FUND, Denver, Colorado.

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Professional Notes

Stress Management: The Importance of Organizational Context

Kathryn L. Goldman

In conducting training programs in leadership, personal growth, and stress management over the last ten years, I have found that support from a person's immediate referential community is as important as the content or quality of the program in producing successful outcomes. If we compare long-term results of working with (1) individuals in public seminars or community college classes, (2) staff groups in organizations without strong organizational support, and (3) staff groups in organizations with commitments and participation of top executives, the importance of the organizational context quickly becomes evident. *Organizational context* refers both to organizational support of a particular program and to the degree of overall openness of the organizational climate.

As clinical sociologists in a society where personal development programs are normally conducted by professionals trained to focus on individual psychodynamics, this perception deserves our attention. Research shows that longevity and health are correlated with a person's marital status and degree of social integration. Stress-management training programs do not generally reflect this knowledge; they focus primarily on what the individual can do alone to modify "harmful" response patterns. Clinical sociological research and practice can help us explore ways in which the social and personal domains interact to foster or limit change.

The importance of stress management in our society has received increasing attention over the last decade. The writings of Benson (1976), Pelletier (1977), and others, along with numerous tapes and classes, offer the individual a sound basis and clear, effective methods for managing stress. Most commonly, such training presents the basic concepts about stress, allows participants to discover their own stress level, teaches them to identify stressors and improve coping methods, and trains them in one or more approaches to relaxation (namely, Benson's "relaxation response," Jacobson's progressive relaxation [1938], breath work, meditation, and/or mental imagery). From conducting stress programs, I know that people enjoy the sessions and report feeling relaxed afterward. What, however, will lead them to alter their normal, habitual responses to everyday stressful situations? Will the combination of heightened self-awareness and in-class practice provide sufficient motivation for changing deeply ingrained modes of action-under-pressure, when these are literally "wired into" the nervous system? Although the physiological aspects of stress management are critical, the situational components of problems and alternative social and personal strategies are equally important, as suggested
by the following cases. The sharp contrast in long-term effects between two programs I conducted (one for the training unit of a large state hospital and one for a small, private business) convinced me of the contribution of the social environment to effective stress training.

Case A: The Hospital Setting

The hospital program was set up by the training director in an attempt to improve a difficult situation: the unit educators responsible for staff training had little sense of working as a team, were geographically dispersed throughout the hospital grounds, and had practically no voice in establishing the content of their educational programs. The training director initiated the program on the suggestion of one unit educator, but did not participate personally. Of the twelve-member group, at least one-third had been recruited from hospital staff to work as half-time trainers and did not really want the position. Since the hospital had roughly 100 percent turnover in employment at lower staff levels every year, training was a constant series of basic orientations. Almost everyone felt disgruntled and overworked.

I had planned to interview each of the unit educators individually in order to establish a one-to-one relationship, learn their perceptions and needs without their feeling observed by the supervisor, and build a sense of personal commitment to the possibility of using this program to promote change. The director did not deem this necessary or financially feasible. Although individual interviews are optimal in consulting in such settings, I opted to schedule several meetings with the associate director and one highly involved unit educator. I also arranged a pre-session meeting for group input and discussion, but few educators attended. (Several staff members from other parts of the hospital wandered in, looking for a different meeting — and one stayed over fifteen minutes before realizing that she was in the wrong place. No one in the group commented on her presence in any way, even though they knew she was not part of their team!) In spite of the fact that the sessions directly addressed issues of powerlessness, team building, and organizational change strategies, the unit educator group as a whole never accepted the program as a tool for positive change. Individual members found it personally and professionally valuable, but pre-existing schisms in the staff kept some in a blaming stance. They saw this as just another imposition from above.

Case B: The Business Setting

Working with the private business was a total contrast from the hospital. Although it was a comparably high-stress work setting, management was fully committed to maintaining a high level of direct, personal interaction. The
company was a rapidly growing quick-copy service with several branches in three cities. Many executives and managers had been with the company for most of its nine years. Staff and management socialized together often. The president sponsored and attended the seminar, and allowed me access to employees for preliminary interviews on company time. I spoke with the executive vice president, several middle-level managers, and workers from various departments and branches of the company. During these informal talks, all felt free to discuss both their work and personal goals unrelated to the business. It was fully acceptable on their biannual self-reviews to present non-business goals as primary; no one pretended a devotion they did not feel.

While at the hospital attendance was required and resented, at the copying service it was voluntary and enthusiastic. Management provided lunch, and individual managers participated fully and honestly. Although the general level of stress was extremely high — over 300 on the Holmes-Rahe Social Readjustment Rating Scale — the president herself had a very low score. Her perception of the need for such training in the organization was accurate.

A year later the president wrote of the program’s impact: “We are still seeing the beneficial impact this seminar and the follow-up work had on our employees. Individuals will comment during meetings or conversations on a fairly regular basis that they use various techniques you suggested, and which you had us practice that day.” Although the stress-level scale indicated that illnesses could be expected within two years in the absence of good coping skills, in the year after the training session there were no serious illnesses; absenteeism and turnover decreased; and there was only one accident requiring hospitalization (involving an individual who did not participate in the seminar). Within this year the president retired (while in her early forties), sold the company to the employees, and the executive vice president moved into the position of president.

Open Versus Closed Organizational Contexts

What accounts for the tremendous differences in effectiveness of the stress management training in these organizations? At the copying service it was obvious that individual actions made a difference to the company, learning was encouraged, and managed organizational change was a fact of daily life. At the hospital, individuals felt like cogs in a huge machine; even though the training director encouraged learning, her personal noninvolvement in the program suggests the prevailing adherence to bureaucratic hierarchies. The copying service is the most open organization I have ever witnessed, while the hospital is an exemplary model of a closed organization. Openness in the model I use means: (1) having a clear, shared sense of purpose (Unity); (2) maintaining active, responsive patterns of communication within the system
(Internal responsiveness); and (3) remaining open to ongoing readjustment of purpose in response to the shifting needs of the surrounding community (External responsiveness) (Goldman 1979).

When I used this model in a study of community colleges, I found that students felt a sense of greater control over their own lives in those colleges that were the most open. Feldman and Newcomb's thorough compilation of research (1969) suggests that college students' values and behavior are not strongly affected by the content of their courses — a conclusion supported by Jencks (1972). Similarly, Schmuck and Miles (1971) concluded that "most efforts at educational reform have collapsed or have been absorbed without effect precisely because of the limited attention given to the organizational context..."

In my teaching of leadership and personal growth in a community college, I have found the environment to be an equally important factor in the outcome of personal learning. I believe this is an important area for clinical sociology. By integrating contextual awareness into programs designed to help individuals manage stress and growth, such efforts are more likely to produce satisfying long-term results.

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OTHER RESOURCES

This exercise is designed to allow students to identify the values that are important to social interaction on several levels. The exercise is useful at the introductory level to sensitize students to the effect of values on their own choices, and to identify the social categories around which individuals develop values. It may be adapted to focus on micro-level interaction (e.g., within couples) in a course such as Marriage and the Family, or on interaction among groups (e.g., within a neighborhood) in courses such as Urban Sociology or Community. In using the exercise in Introductory Sociology, an appropriate placement might be as a supplement to material on socialization, or in a unit on general patterns of social interaction.

The exercise is called a “Planning Board.” Students need to be supplied with two sheets of 8½ × 11 paper, and need a pen or pencil. I introduce this exercise by telling the students that it is a Planning Board, and that the purpose of the exercise is to help see the relationship between individual choices and sociological variables.

The first instructions are technical. Each student divides one of the sheets of paper into twelve sections, by dividing the sheet in half vertically, and creating six sections on each side by drawing five horizontal lines to create equal-sized sections. The second sheet of paper is torn into twelve pieces of the same size and shape as the sections drawn on the first sheet. To save time and confusion, I usually provide each student with a previously prepared grid sheet, and use removable stick-on memo notes for the slips of paper. The twelve sections of the grid sheet are numbered from one to twelve, usually using the six sections on the left side of the paper first, from top to bottom, and proceeding to the right side of the sheet, top to bottom.

I explain to the students that the small slips of paper will be used to write down key words, which I will give to them, and that I will provide these key words or phrases one at a time. Each slip of paper will then be placed on the grid sheet in the position of priority, from one to twelve, the student feels it occupies in her or his hierarchy of choices with regard to the issue at hand.

For instance, the issue may be “intimate relationships.” I present each key word or phrase (e.g., “being able to be totally honest”), and instruct the students to place that slip of paper in the relative position each feels this aspect of a relationship would have for her or him. I usually explain this by saying to...
students, “How important is it to you to be able to be totally honest with the person with whom you have or would like to form an intimate relationship? Place this slip of paper in that position on your planning board.” I then pause while each student does this. Then I give the key word for the second item: “Similar religion; how important is it to you that the person with whom you have or would like to form an intimate relationship be of the same religious background as you are?” Again, there is a pause while students place this slip of paper in the appropriate section. This format is repeated with eleven items, with physical placement of each slip of paper after each item. As more items are placed on the planning boards, students find that they wish to move slips up or down on the priority list; that’s fine. In a sense, it is the basic point of the exercise: many things have to be balanced against each other, and priorities established, in making such evaluations.

Eleven items that I have used are:

1. being of equal intellectual ability
2. being able to be totally honest
3. having the same religious/spiritual interest
4. good sexual interaction
5. being socially skilled (can “dress up and take out”)
6. potential for earning a lot of money
7. fidelity
8. being involved in a meaningful career
9. being physically attractive
10. willingness to be flexible and make changes
11. willingness to work on problems (to “stay up all night”)

The twelfth item is always a “wild card,” an attribute or characteristic that has not been mentioned in the first eleven items. I also change or tailor specific items each time I use this technique, with the particular group in mind. Depending on the level of trust in the group, I may ask members to share any reactions or feelings they had while doing the exercise, or the order of their choices.

The exercise is adaptable; if I wish to focus on macro-level variables, I include items such as “social class; how important is it to you that this person be of the same social class background as you are?” Ethnic background, region of the country, not having been previously married, and being near in age are some other possibilities. If I am working with a class or group interested in further applications of this technique, I suggest that the individuals redo the exercise, using the same slips of paper, but this time arranging the slips in the order that they think the person with whom they have or want to have an intimate relationship would rank them. In some cases, I also suggest that they
might wish to have the other person see and react to both the initial listing and the attempt to replicate the other person's priorities. This I would probably do in a Marriage and Family course, or in a course that focused on building relationships. I have also used it in a rap-group setting, with both members of couples present.

Another adaptation is to have students think in terms of groups within neighborhoods: "How important do you think it is for people in a neighborhood to be of the same ethnic group? Religion? Political philosophy? Sexual preference/orientation? Social class?" Again, the items are offered one at a time, and each slip is placed on the planning board, so that conflicts or changes in priority must be recognized and handled by physically moving the slips of paper around.

I have found students and members of groups other than classes to be very responsive to this exercise. It does not take a lot of time; a one-hour class period has proved more than ample to do the exercise and have some time available for discussing and processing. I also believe that, while the exercise does raise issues and concerns about membership in various social categories, it is safe and appropriate for classroom use.
Evaluating Teaching Effectiveness

Thomas J. Rice

The literature on effective teaching is, like most other scholarship on teaching, becoming both sophisticated and voluminous. However, empirical findings on teaching effectiveness are notably inconsistent (Wagenaar 1979) and are not likely to support reliable generalizations for some time into the future. Given that the assessment of teaching is becoming central to administrative decision making in this era of academic “hard times,” the following questions must be addressed: (1) What assumptions lie behind the evaluation of teaching? (2) Why evaluate in the first place? (3) What do we know about evaluation at the present time? (4) Who should do the evaluation of teaching? (5) When should it be done and how often? (6) How can it be done to ensure both validity and reliability?

Assumptions

Before any evaluation can begin, it seems critical that all participants articulate and share a set of assumptions from which the evaluation process may go forward. A number of scholars (for example, Eble 1976; McGee 1974; Wagenaar 1979) have advanced inventories of assumptions. Several seem to be rather commonly accepted; for example, it seems to be agreed upon that (1) effective teaching is a socially learned competence, not an inborn attribute; (2) effective teaching can be analyzed into its component parts and reproduced in a range of settings; (3) major components can be measured through research methodologies; (4) while “great” teachers may have some qualitatively ascribed characteristics, “good” teachers can achieve this assignation through conventional learning formats (that is, analysis of methodologies and feedback toward a change in behavior); (5) no single method of evaluation is adequate to the task of assessing the effectiveness of teaching, but a triangulation, or multimethod approach, should be employed; and (6) teaching effectiveness should not focus on the professor alone, but on the interaction of forces and factors in the social space that encompasses the learning context.

Reasons for Evaluations

The question “why evaluate?” is answered most thoroughly by Grasha (1977). This question is more complicated than any other question posed, since it involves both a practical pedagogical aspect and a political consequence. Grasha assumes that feedback improves performance; to the degree that evaluation provides feedback, teaching should improve. The application of this relatively
simple principle is, however, subject to a great deal of faculty resistance because of the political and professional sensitivity of such processes.

We evaluate teaching because it: (1) provides for an atmosphere of participation and cooperation between faculty and students in the quest for excellence in teaching; (2) sets standards for excellence that are shared in the community of intellectuals and that aid in the sifting-sorting processes of the "academic marketplace" in ways that do not perpetrate arbitrary decision making; (3) motivates teachers to make teaching the top priority of their institutional responsibilities; and (4) furnishes reliable feedback to teachers as to their impact on students and colleagues so that they may modify their teaching repertoire toward greater effectiveness in the classroom and outside it.

The efficacy of teaching evaluation programs in reaching such a desirable set of goals remains an empirical question.

The Nature of Teaching Effectiveness

The third question actually asks, What does our research tell us about teaching effectiveness? In the most meticulous review of the research to date, Wagenaar (1979) concluded that the literature supports ten major generalizations:

1. No significant relationship exists between Student Evaluation of Teaching (SET) and age, sex of instructor, sex of student, experience, or severity of grading.
2. Student characteristics are crucial, such as ability, predicted achievement, etc.
3. There is a negligible relationship of SET with research productivity; i.e., productive professors are no less, nor are they more, effective than their less productive colleagues, as measured by publications.
4. A high level of agreement exists between faculty and students on the basic characteristics that make for excellence in teaching.
5. There is a modest negative relationship between size of class and teacher ratings, though this is reduced somewhat when a control is introduced for required courses and course level (both are negatively related to SET).
6. There is no consistent relationship between SET and grades, final exam scores, and other tests, although such dimensions as student interest and faculty/student interaction seem to be moderately positively correlated with achievement.
7. The reliability for student evaluations of teaching is high (87% but quite low for colleague ratings (.57).
8. Students are rather generous in their rating of teaching: the mean is 3.8 - 4.0 on the typical 5.0 scale.
9. Several underlying dimensions repeatedly emerge as absolutely relating to good teacher performance, usually based on factor analysis:

   a. structure/organization/preparation
   b. interpersonal (tolerance, sensitivity)
   c. professional (knowledge, examples, interrelationships)
   d. skill/communication/clarity
   e. motivation (stimulation, encouragement, enthusiasm)
   f. assignment/evaluation (perceived fairness)

10. The greater the salience of an item of evaluation for the student, the higher the correlation of that item with the overall rating of teaching.

**Participation in the Evaluation**

The question, **Who should do the evaluation?** has a fairly consistent response in the literature. The answer is: *everyone affected by the outcome*. This clearly includes students, colleagues, professional evaluators, administrators, and the teacher in question. Such "triangulation" is the most valid and most acceptable approach, though it is also the most expensive.

**Timing of Evaluation**

As mentioned earlier, ongoing evaluation provides more effective feedback than end-point questionnaires: teaching adjustments can be made while the course is still in process. The most promising model seems to be one of regular, but brief, evaluations of lectures, discussions, and other formats. Coupled with these evaluations, I suggest a comprehensive mid-semester review of the teaching process; similarly, the end of the semester evaluation should be comprehensive. Since students and classes differ in their responses to various teaching methods and learning experiences, discrete assessment and feedback can take place and adjustments can be made.

**Evaluation Methods**

Questions about evaluation methods are probably the most interesting and useful to raise for most teachers. There is little consistent instrumentation for the introductory course, though a few principles have been advanced to aid in the development of instruments. These may be summarized as follows:

1. A combination of objective and subjective questions provides the richest and most reliable data.
2. Questions should be developed that relate to the learner, the instructor, and the substantive content of the course, as well as any other relevant factors that may have entered the learning context.

3. Short evaluation instruments are more effective for soliciting information than are long ones, provided that these are concentrated on salient parts of the teaching process.

4. With regard to the questions about the instructor, the six dimensions (structure, interpersonal, professional, skill, motivation, and assignment) should be made explicit.

One of the most comprehensive sources of instruments for evaluating teaching can be found in *Passing On Sociology* (Goldsmid and Wilson 1980). Most of the instruments have been fully tested for reliability and validity, thus resolving technical issues. However, the most difficult part of teaching evaluation has probably never been the technical aspect. As long as human institutions are arranged so that the destiny of one group is tied to the evaluation of another, the major problems will be political and social in nature. This is clearly more complicated than simply getting an instrument that works.

**Guiding Principles**

Grasha approaches the problem of guidance by suggesting eight principles of evaluation that, if activated, would serve to reduce resistance and render the idea of evaluation both practically and politically attractive (elicited from Malec 1978):

1. **There is no perfect evaluation system.** This does not mean that evaluation is impossible. It suggests that “current procedures will improve faster if people are willing to assess the advantages and disadvantages of their practical experience” (12).

2. **Assessment activity should be broadly based.** Teaching is multidimensional as an activity. Too often only one activity and one data source (students) become the sole basis of evaluation. The learning gestalt should be included — teachers, students, content, institutional context, faculty advisers, and so on.

3. **Evaluation must be linked to the reward structure of the institution.** In other words, the evaluation must not be a perfunctory exercise carried out to meet unknown bureaucratic imperatives. It must be meaningfully linked to recognition in the form of salary, promotion, or other tangible rewards.

4. **Evaluation is best considered a process rather than a terminal event.** This principle implies that the model of evaluating a course through one student questionnaire given at the end of the semester is unsatisfactory. It seems more appropriate to gather several data sets as the course unfolds so that the inclination and possibility to respond are immediate.
5. Evaluation systems should allow for the assessment of interindividual differences and for the assessment of personal goals and objectives. In other words, the evaluation process must recognize that each teacher has unique features that should not be diminished in a monolithic evaluation process.

6. Evaluation systems should maintain personal and career growth and development focuses. A system that attempts only to provide a data base for promotion, reappointment, or tenure or to "hire and fire" is an empty system and eventually encounters resistance. "Development must be an issue from the beginning to insure the long term survival of evaluation procedures" (15).

7. People who are affected by a system of evaluation should participate in its development.

8. Attempts to make personnel decisions on the basis of an objective quantification of assessment data should be avoided.

While these principles serve as a blueprint for the ideal teaching situation, and are not likely to prevail in the experience of most teachers, they point us toward some of the best reasons for having a program of evaluation.

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Book Reviews

Introduction

Jean H. Thoresen, Book Review Editor

The following book reviews address some important issues for clinical sociologists and serve to focus attention on our emerging disciplinary identity. Harry Cohen's work presents an attempt to link specific sociological theories to direct clinical intervention. Marie Matthews calls for a rapprochement of social work practice with sociological thinking, analysis, and data, a position similar to that advocated by John Glass and Jan Fritz (1982) in terms of the needs of clinical sociology as a field. Monica McGoldrick's edited volume suggests how a sociological variable may be translated into the basis for a specific type of clinical practice.

As both Betty Reid Mandell ("The study of ethnicity has been late in coming to professional schools . . .") and Leo Miller (". . . social work failed to give sufficient attention to the new positivistic source of sociology . . .") emphasize, sociological thinking has been less than fully utilized by practitioners in various fields. It is important, however, that as clinical sociologists we do more than lament the lack of input from sociology and by sociologists into other disciplines or practices. Developing clinical sociology as its own recognized field is at least equally important, perhaps more so.

The early practice of sociology, as well as social work, as Leo Miller points out, developed from the interests and commitments of similar groups of people. Robert E. L. Faris (1967) elaborates in his "Heritage of Sociology" volume, Chicago Sociology 1920-1923, the connection between theory and practice within an urban context in an earlier era. Alfred McClung Lee's proffering of humanistic sociology as a basis for practice is complemented by the larger tradition of clinical sociology as presented by Louis Wirth (1931).

What is it that is special about clinical sociology? What is it that suggests clinical sociology as a particularly heuristic and effective perspective from which to assess and understand both human behavior and effective intervention for change or amelioration? Perhaps we can speak here of the connections among practice, theory, and research.

Books like Cohen's are part of a valuable tradition which recognizes that sound practice must be based on sound theory. The necessity for sound theory in turn supports the classical research orientation of sociology. If the study of ethnicity has only recently informed practice, it is not because of a dearth of sociological studies emphasizing the importance of ethnicity; to remain within the Chicago milieu for a moment, it would be difficult to overlook The Polish Peasant in Europe and America (Thomas and Znaniecki 1918 et seq.) as a landmark contribution to sociological theory and research. Sociologists are in
a unique position to assess the effects of an element of human social organization (membership in an ethnic group) that is often treated only as a macro-level variable, on the micro level as well, in terms of its specific impact on a particular family system. This sort of linkage of macro and micro levels of theory and practice offers fertile ground for sociological growth.

Sociological theory moves easily between these levels and incorporates as well what is identified in Mandell’s review as the “mezzo” level (cf. Merton 1957:9). Recognition of a continuum between macro-and micro-level concerns, rather than a dichotomous polarity of positions, is well within the sociological mainstream. There is a need to increase understanding of the ways in which both theories of the middle range and grand theory can be translated into clinical intervention strategies. The books reviewed in this issue contribute to our understanding of such connections.

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Review Essays


Reviewer: Betty Reid Mandell

Ethnicity and Family Therapy is a comprehensive collection of articles that addresses ethnic issues in family therapy, and it is apparently the first such collection to be published. It is divided into three parts: (1) the conceptual overview, (2) the paradigms, and (3) the special issues. The paradigms includes nineteen chapters on different cultural groups, combining, in varying degrees, historical, cultural, socioeconomic, and demographic information with a discussion of appropriate treatment methods, often illustrated by case vignettes. The authors are professionals in the mental health field — social workers, psychologists, and psychiatrists, plus one anthropologist.

The study of ethnicity has been late in coming to professional schools, and sometimes has been incorporated in the curriculum. Because the literature on ethnicity is so sparse, it is always a pleasure to greet a good new book on the subject. After reading Ethnicity and Family Therapy, I saw more clearly how ethnic understanding might be applied to family therapy.

Yet, as I read, I had an uneasy feeling that these “simplified pictures of the cultures, ‘snapshots’ frozen in time” (McGoldrick, Pearce, and Giordano 1982:xv) could also perpetuate cultural stereotypes. The authors, too, had this uneasy feeling, admitting that these snapshots could be misused (xvi). Anyone with a modicum of exposure to other cultures knows that a good many Chinese and Puerto Ricans do not lower their eyes to avoid direct eye contact, nor do all British Americans serve roast beef to the family on Sunday. We all probably know Irish who do not drink heavily, Italians who do not eat heartily, and Greeks who do not run restaurants. And many WASPS are lazy and show no initiative whatsoever, nor are they all optimistic — many, in fact, commit suicide. Of course, all Asian cultures cannot be lumped together, as they are in the chapter “Asian Families.”

James Green, a cultural anthropologist, describes (1982:9) two broad categories of explanatory models to account for ethnicity: those explanations that focus on categories of behaviors and traits, and those that approach ethnicity in a “transactional” way, focusing on strategies for defining and preserving cultural differences. Categorical approaches tend to pigeonhole, while transactional approaches study ethnicity as one of the ways that people find meaning in communication. In Ethnicity and Family Therapy, Falicov, writing about Mexican families, notes the problem with a categorical approach:
Broad cultural generalizations do not do justice to regional, generational, socioeconomic, and idiosyncratic variations in lifestyle found in Mexican American families. . . . Cultural norms tend to refer to the *public* reality of how relationships or behaviors "ought" to be. These internalized behavioral prescriptions sometimes do not coincide with *private* realities, that is, how things "really" are for each family. . . . (137)

The articles in *Ethnicity and Family Therapy* reflect both approaches, but put a heavier emphasis on the categorical approach. Those authors who take a systems or ecological approach, however, try to view ethnicity in a broad historical and socioeconomic framework. In "An Ecological Model of Ethnic Families" John Spiegel attempts to take that approach. He presents a typology of ethnicity in relation to Kluckhohn's value orientations (1951; 1961). Yet, even placing ethnic groups in a particular category of values can again fall into pigeonholing; the American middle class is future oriented, so they work hard to achieve; the Italians, however, are more present oriented, so they talk less about their work when they come home.

In her overview, Monica McGoldrick mentions the importance of looking at social class, religious and regional identities, and gender, in addition to ethnicity. Still, she does not propose an orderly typology to use in studying ethnicity. In contrast, in *The Ethnic Dilemma in Social Services* (1981) Shirley Jenkins proposes a useful typology that specifies important variables to be considered in determining the strength of the ethnic variable. Her typology proposes three levels of analysis: micro, mezzo (intermediate), and macro. The levels of analysis that I found particularly weak in *Ethnicity and Family Therapy* is the macro level, which considers the political climate on a national level. Jenkins points out that while cultural pluralism in the United States "is essentially documented by demography," its social acceptance was brought about by political movement of ethnic groups that forced concessions from the sources of national power. Thus, "ethnicity in service delivery received more support from the 'maximum feasible participation of the poor' in community programs than from any ideological concern with 'role' or 'identity'" (1981:1961). Jenkins pays more attention to these political factors than do many of the authors in *Ethnicity and Family Therapy*, in which the political thrust often seems to follow the motto "Our status is quo, come weal or come woe." Spiegel summarily dismisses Rousseau's "Good-but-corruptible" view of human nature as "Held today by only a few 'flower children,' most of whom have disappeared into rural settings where they can cultivate goodness far from wicked civilization" (42). Attneave dismisses the occupation at Wounded Knee by Native Americans as "impractical but admired, much like the Charge of the Light Brigade" (64).
There are no outspoken feminists in this company of authors. For most of them, the patriarchy will remain firmly in place after the therapy is finished. The one universal value in all ethnic groups is the patriarchy. Falicov draws on functionalist theory to justify this, discussing an alliance between mother and children: "Sociologists regard this type of alliance between mother and children as functional when parental role segregation is high (such as in the patriarchal households of technologically simple societies) and will not label this pattern as 'pathological stable coalition' in need of change" (141). Spiegel shows how this works out in practice: "Because we are dealing with families based on Lineal or Collateral orientation, it is important to line ourselves up with the head of the family. This is normally the father; . . . we would not be able to get very far if we indicated that one of our goals was to obtain autonomy or individuation for a wife or daughter" (48). He illustrates this point by an interview with a Puerto Rican father in which the therapist "agreed with the father's view about the importance of maintaining control over his daughter's activities and preserving her virginity" ["Respect for the male role being of prime importance in Puerto Rican families" (49)]. This theme is repeated by Falicov in "Mexican Families"; " . . . addressing questions to the father first, then to the mother, then to other adults, and finally to the older and younger children, respects traditional age/sex hierarchies and conveys respecto"(151). Yet Falicov also suggests the alternative of allowing the family to elect its own spokesperson, and is one of the few authors who discusses the validity of sometimes opposing cultural norms which "inhibit the development of personal identities." Garcia-Preto in "Puerto Rican Families" repeats the advice to address the husband first but is also the only author to suggest women's self-help groups to support the woman. Shon and Ja also tell us to address the father first in Asian families (223), and, according to Welts, a Greek woman who marries a non-Greek man "will be a satisfactory sexual partner since she has been brought up to believe that wives must be sexually accommodating to their husbands" (280). Jalali advises the Iranian family therapist to join with the father, acknowledging his hierarchical position in the system (304) and addressing the father first (308). While advocating strengthening of peer relationships and the father-child relationship in order to weaken mother-child bonds, he never suggests support groups for the women. Jalali not only reinforces the patriarchy (never mentioning the small but influential feminist movement in Iran); he is also an apologist for an authoritarian government: "Iranians' sense of individuality has always been so powerful, that authoritarian controls have had to be exerted to ensure their allegiance and support" (292).

After all this deference to the father, I was relieved to read in Rotunno and McGoldrick's "Italian Families" some suggestions for fostering individual initiative in family members other than the father: "The father could be com-
plimented for creating a family in which each member took individual initiatives that reflected positively on the family" (351). Yet, turning to Portuguese families, we again find the therapist beginning with deference to the father, to whom “initially all remarks should be directed” (427). Treatment of a man who beats his wife and child was successful when he shifted from physical to verbal abuse (430). Interestingly, the only chapter that lists as a primary goal of therapy the increase of opportunities for independent achievement for women was the one on British families by McGill and Pearce. A single mother is recognized as “overworked and undersupported” in “Intervention in a Vietnamese Refugee Family” by Lappin and Scott. However, family therapy with an Indian family is declared successful when the woman is scared into submission (Landau, “Therapy with Families in Cultural Transition”). A male Indian “link therapist” (member of the family who is coached to do therapy with the family) persuaded his uncle to lecture the mother and girls on how to behave:

**Ganesh:** My mother is scared of my uncle, and she was silent as soon as he came. She listened to every word.

**Therapist:** So, you are happy about things now?

**Ganesh:** Yes, things are coming straight now.

Problems were once more resolved according to strict traditional prescription within the boundaries of the family system (564). No one asked the scared mother if she thought the problems were resolved.

The chapters I liked best gave a rich historical and cultural background, showed some political sophistication as well as sophistication about treatment techniques, and did not propose techniques to keep the women and children in their place. These included Hines and Boyd-Franklin’s “Black Families,” Pinderhughes’ “Afro-American Families and the Victim System,” Attneave’s “American Indians and Alaska Native Families,” Brice’s “West Indian Families,” McGoldrick’s “Irish Families,” Midelfort and Midelfort’s “Norwegian Families,” Lappin and Scott’s “Intervention in a Vietnamese Refugee Family,” and Garcia-Preto’s “Puerto Rican Families.” “Portuguese Families” by Moitoza drew upon the author’s original research, and therefore seemed more authoritative than some.

Several of the authors gave astute suggestions about differential treatment, pointing out strengths and weaknesses of various treatment methods. “Paradoxical” treatment struck me as usually manipulative and sometimes downright dishonest. Sluzki’s “Latin Lover Revisited” seemed padded, with a thesis that could be stated in a couple of sentences: the Latin lover is in the mind of the Anglo woman. Not being accustomed to standing as close to people as are Latino people, she assumes that she is being seduced and signals that assumption to the Latin male, who has been acculturated to believe he must always be ready for sex, and responds to her assumptions by becoming her
stereotype of the Latin lover. This logic struck me as a bit like blaming the victim.

Friedman’s “The Myth of the Shiksa” presented the most carefully thought through theoretical formulations, though I did not wholly agree with them. The author’s thesis ran counter to those in most of the articles, arguing that cultural traits are used as camouflage to cover up basic and universal emotional processes. Friedman argues that the therapist’s focus on values and ideological positions “is often just another form of displacement. To offer reasonable alternatives to such positions, therefore, is once again only to conspire in the family’s denial of its emotional process” (526). By the way, Friedman has the best sense of humor of any of the authors. His prescription for stopping a Jewish mother’s nagging of her daughter about marrying a non-Jew is worth passing on. The Jewish daughter is advised to send the following letter to her mother:

Mother, I know you are opposed to John, and you have a right to your position, but you are still my mother and I believe you owe me one more thing before John and I marry. We have never had a frank talk about sex. What has been the secret to your marital success? How many times a week would you say a man likes it? And when you don’t want it, how do you keep a man away? (513)

I think this book could have been improved by more detailed attention to the effect of the therapist’s ethnicity and social class. In cultures where a language other than English is spoken, authors always said it is preferable (practically essential, in fact) for the therapist to speak the same language, but they did not go further than to discuss the research on this subject. It would also have helped to have had more anthropologists involved in writing articles, and to discuss at greater length how therapists can go about learning more about cultures. As the authors admit, this book is only a beginning. James Green offers some good cultural study guides for social workers, borrowed from anthropological methodology.

Ethnicity and Family Therapy could also have used some more imaginative suggestions for increasing a culture’s own ethnic understanding and pride. The authors would have benefited from reading Jane Addams, whose ethnic museum of work did so much to help the children of Chicago immigrants understand their parents’ work and values. In addition, some data could have been updated by using 1980 Census figures.

The chapter on Irish families is artistically rich, since it draws heavily on literature. It is also one of the most anthropologically solid chapters. However, all the chapters could have dealt more thoroughly with social class. Oscar Lewis believes that in some ways social class is a more important deter-
ominant of behavior than ethnicity. An upper-class person in Mexico may have more in common with an upper-class person in the United States than he or she has with a poor Mexican. While several authors mention the importance of social class, the only article that deals with it in depth is that on the Iranian family, which alone focuses on upper-class people and their needs. The article on black families by Hines and Boyd-Franklin could have been strengthened by a fuller discussion of the black bourgeoisie as compared to poor blacks.

I would not want my criticisms to discourage people from reading this book. *Ethnicity and Family Therapy* contains some rich information and ideas for family therapists and, I hope, will stimulate the reader to study more deeply the ethnic groups with which she or he is working.

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Kluckhohn, C.


Reviewer: John F. Glass

*Connections* is a unique and engaging book. Cohen writes clearly and in a lively and personal style on how sociological knowledge can be used for group and individual improvement. This is not a self-help book; Cohen’s study is theoretically sound and contains many examples and cases to clarify and explain.

Each chapter covers a major sociological perspective: symbolic interactionism; the exchange perspective; conflict theory; dramaturgical analysis; labeling; and structural functionalism. Cohen clearly explains these perspectives, how they are useful as guides for qualitative research and understanding about human behavior and the social world, and how they can be applied to
clinical interventions. Each chapter concludes with a practice section full of provocative questions and guidelines that are directly useful to therapists and other practitioners working with individuals, groups, families, and organizations.

The discussion of symbolic interaction teaches us about how self-concepts are formed, maintained, and changed through communication, how we use language and symbols, and how symbolic meanings are important to relationships of all sorts. A marriage counseling case is included in the appendix for practice in the use of this perspective.

Exchange theory enlightens us as to the essence of social life — how relationships are linked by give and take, how they sour when exchanges are faulty or fall into ruts. Here the reader is guided by some thirty-five useful analytic questions, such as: What are the expectations? What is given and received? Where is the power and stake of each participant? Where are the dependencies? Are there coalitions? Are there negotiations? If so, over what issues and with what effects?

Dramaturgical analysis is useful in understanding and using roles and role playing. From labeling theory comes the famous Thomas theorem, "If people define situations as real, they are real in their consequences" — a most useful guide for understanding behavior in social settings.

Structural-functional analysis helps us understand interdependencies, balance, and change in relationships and social systems, and enlightens us about social order and disorder and about manifest and latent processes. Here the questions for practice guide us to boundaries, criteria for determining function and dysfunction, and points of stress and strain. This kind of analysis is also most relevant for the group and organizational consultant.

Connections confirms and consolidates much of what clinical sociologists have known, practiced, and preached in recent years, to wit, the enormous value of sociological thought and analysis for counselors, therapists, and other change agents. Although this book is written as a text for students and is ideal for use in courses dealing with counseling, social psychology, and even theory, Connections is just as useful to the practitioner as an introduction to or a convenient reminder of the basic sociological principles that underlie so many of our therapies and intervention strategies.

Reviewer: Leo Miller

Dr. Marie A. Matthews is a sociologist with a background in social work. As the title of her book suggests, she has set for herself the task of historically tracing and analyzing the "mystique" in social work. She sees this element as resulting from a series of historical choices or options that were not recognized clearly "as selected solutions among other possibilities." These options included (1) an identification with the Charity Organization Society (COS) model and philosophy; (2) the turn toward psychiatry and the psychoanalytic mode; (3) the achievement of professional status based upon the search for the generic; and (4) social work's current relationship with the social sciences and with sociology in particular. The result of taking each of these fateful turns without sufficient consideration of alternatives has over the years been reflected in problems concerning the theoretical foundations of social work, a special methodology, and modes of practice.

Unfortunately, the author does not devote corresponding efforts to the analysis of similar historical and reality problems in the field of sociology. Both professions sprang from miscellaneous groups of clergy, philosophers, reformers, radicals, and those persons concerned with maintaining the status quo. Both have been concerned with erecting and maintaining professional facades, using esoteric terminology, and the manipulation of students and/or clients.

By strongly turning toward the COS model, which was established to organize and rationalize charity in the latter part of the nineteenth century, social work failed to give sufficient attention to the new positivistic source of sociology, as reflected in the empirical studies of Charles Booth on the laboring classes of London. It also turned away from the reformist orientations of the Fabian Socialists. The result was a concern with character and class consciousness, rather than with poverty and social reform. This imbalance was later furthered by the turn to the psychiatric, with a corresponding neglect of the social component. The generic concept is viewed as a magical element intended to justify professionalization by means of a common thread of social work ministrations and the development of specialties. Matthews finds no core content to this "will-o'-the-wisp" search, which tends to undermine real social policy concerns. She is, however, very concerned, as a sociologist, that social work incorporates the methodology and knowledge of the social sciences.
Matthews devotes considerable space to nineteenth-century human service pioneers such as Charles Booth, John Augustus, and the Barnetts; however, she does not see these “ancestors” as being in the direct line of social work development. One wonders also about the lack of emphasis placed upon the great period of social reform in America at the turn of the century, so well described by Robert Bremner. Perhaps it is a matter of definition as to what should be included in the direct line of social work.

The author appears to be sincerely committed to social work and desirous of facilitating its more rigorous development. She is to be commended for raising a number of issues in the field and for tracing their past and present connections. A social worker might be excused, however, for feeling that Matthews may have underestimated the worth of its practice, the skill of its practitioners, and real efforts which have been made to establish its theoretical bases. This applies especially to social casework, which comes in for much criticism.

Most of the references cited by Matthews are from the year 1965 or before, so that more recent works, such as those of Ruth Butler and Carel Germain, relating to integrated theory and practice, are missing. In addition, no mention is made of the definitive report (vol. 6) of the 1959 Curriculum Study of the Council on Social Work Education. This report together with a later council monograph by Butler on the Social Functioning Framework were designed to establish an approach to the Human Growth and Social Development Sequence. They address themselves to the knowledge and value basis of social work and to their integration in the provision of services.

Certainly social work is not the only profession that could be accused of having made wrong turns. The history of medicine, for example, might offer a similar example. In a larger sense, however, the concept of “wrongness” must be considered as relative and as influenced by hindsight. A related but perhaps more important concern might be the author’s failure to specify what type of present-day sociology would be most useful to social work. Neither profession can escape a concern for real social problems and needed social reforms, if indeed these do not form a basic raison d’etre for both. Alfred McClung Lee has suggested that humanistic sociology would be particularly helpful to social work, insofar as it is less concerned with scientism and the mystical “hardness” of social data and more concerned with human values, the continuous nature of social processes, the impact of cultural backgrounds and of the environment, the observer-subject relationship, and implications for social change.

Matthews does note some of the limitations of the social work approach in correctional practice. The effects of social structure and culture, of differential social organizations and social risk on individual behavior are noted as important principles for social workers. The discussion would be enhanced, however, by a broadened view of the special contribution of sociology as ap-
plied to both micro and macro types of social work practice. Particularly relevant fields for sociological contributions might lie in such areas as the systems and processes of social regulation as manifested in the activities of social and health agencies, social epidemiology involving especially the impact of social factors in the environment, the use of a group culture to foster and maintain nondeviant personalities, the societal reaction to deviant behaviors, and the study of the social and moral situations of clients and patients.

Matthews is probably justified in lamenting the field of social work's overdetermined concern with the generic-specific dichotomy. Perhaps it is the very breadth of the field of responsibility claimed by social work that makes it difficult or impossible to seek out a unified principal of methodology for all practice areas. One sympathizes with her strong call for a rapprochement between social work and sociology and for the continuing need to incorporate social science knowledge. One must be grateful to her for pointing up such thought-provoking ideas as social work's individualistic response over the years to problems badly in need of social solutions, its overconcern with self-determination and simultaneous underconcern with the availability of resources that would make the former possible, its professional posturing at the expense of a concern with the individuality and legal rights of clients, the need to set students free from a supervision too heavily grounded in ideology, and the concept of the social worker as the social servant.

The relationship between the two professions should be seen as a two-way process, dealing not only with the application of sociological insights to social work concerns but also with the contribution of praxis to the modification of sociological and psychological theories. The professions have a function in common — to enlighten and lead society to make needed changes in those outmoded social policies that maintain systems producing economic waste, human conflict, and social disintegration.