Clinical Sociology Review

Volume 15 | Issue 1 Article 6

1-1-1997

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ABSTRACT

Clinical sociology has a large, albeit under-appreciated, role to play in helping individual clients. The types of problems addressed by helping professionals can be classified in four major areas, namely *physiological problems, moral problems, problems in living, and role problems.* These are respectively best dealt with by medical, social control, problem-solving, and resocialization solutions. Clinical sociology can contribute to each of these owing to its expertise in social support, socialization, resocialization, emotional competence, and moral competence.

As we approach the new millennium, it is remarkable that the potential which sociology possesses for aiding individual clients who are troubled by personal problems has yet to be fully realized (Straus 1985). While psychology, medicine, and social work are solidly established, clinical sociology languishes in a backwater peopled chiefly by the sociological cognoscenti. The public has learned about the benefits of family therapy, art therapy, and even dance therapy, but the utility of a sociological perspective in addressing personal distress remains largely undiscovered. Given that much individual adversity can only be understood, or overcome, by recognizing its social dimensions, this is an astonishing failure.

In fact, clinical sociology speaks to a panoply of problem areas with a full quiver of unique interventions (Rebach and Bruhn 1991). For several decades now it has been expanding its domain of application, including areas ordinarily considered non-social. In this paper I will essay to outline the full

dimensions of an individual clinical sociology. I will begin with an overview of the sorts of problems for which sociology can be of critical importance and them proceed to an examination of some of its modes of operation.

Areas of Relevance

Traditional forms of solving personal problems have an almost *ad hoc* quality (Fein 1992). Most have evolved over the course of this past century within disciplines largely concerned with advancing a favored strategy. What has generally been absent from their purviews is a panoramic overview informed by a sociological sensibility. When, however, one stands back and assumes a broad perspective, individual problems are rarely just personal. A number of essential factors become immediately evident. Thus, individual difficulties always have a social context (Billson 1994). They are either created in social interactions, expressed in social circumstances, or corrected through social relationships. This enables them to be distinguished form one another along social dimensions. Once this is achieved, it is possible to recognize that some avenues for solving them are more promising than others. Instead of resorting to the "one-size-fits-all" mentality so common among clinicians, it becomes apparent that specific strategies work better in specific circumstances. In other words, for help to be effective, it must address a correctly understood problem in a socially-related manner.

The following are the four primary types of individual trouble. They are respectively: 1) the physiological, 2) the moral, 3) problems in living, and 4) role problems. While this list is not exhaustive, it covers most of the territory dealt with in the helping professions. What is especially important is that each item has a distinctive source and, therefore, a different resolution. Only by understanding these differences can clinicians assist in providing effective relief.

A) The first type of problem, the *physiological*, has a biological basis. These difficulties are occasioned by the body machinery behaving in ways that can be personally painful. Physical illnesses, genetic defects, and corporal accidents fall into this category. Nowadays there is tendency to attribute almost any form of distress to one of these causes (Kramer 1993). Everything from schizophrenia to depression—including the conduct disorders—is routinely chalked up to "chemical imbalances" and them ministered to with palliative medications (e.g., the prozac phenomenon). Despite an overwhelming lack of evidence that neurotransmitters, or genes, are responsible for the bulk of our personal suffering, the assumptions is that further research will inevitably demonstrate that virtually all individual distress has a biological foundation.

We in sociology are naturally quick to take umbrage at this suggestion. Because we are familiar with the potency of social causes, these tend to be the

first to which we look. And yet there are physiological disorders that do require *medical* interventions. Schizophrenia surely has biological underpinnings. Sociologists once believed that schizophrenigenic mothers were this condition's primary antecedent, but this has been largely disproved. Also disproved has been a crude labeling theory that attributes hallucinations and delusions to the agency of social stigmatization. Schizophrenics can indeed benefit from medications in ways that they do not benefit from social manipulations. As a result, neither biology nor medicine can automatically be discounted in favor of strictly interpersonal interventions.

B) The second sort of problem, which is often confused with the first, can be utterly different. When sociologists talk about the "medicalization of deviance," they have in mind treating *moral* difficulties as physical ones (Gupta 1993). The *DSM IV* (APA, 1994) is the primary exemplar of interpreting virtually all forms of human distress as based upon biological disorder (Kirk & Kutchins 1992). Although some current research points to the genetic origins of social violence, most interpersonal nastiness has no demonstrable physiological underpinning. Still, whether we are discussing the truancy of school children or the obtuseness of narcissistic personalities, persons who exhibit moral problems can be difficult to tolerate. Their exorbitant demands and insensitive actions alienate most of those with whom they interact. In short, they are not nice people. The real question is, therefore, what sort of problem are they? Although such malefactors can accurately be described as having broken important rules, this must not be confused with their having been impelled to delinquency by physiology. To be a problem, is not necessarily to be a "medical" problem. Rule breaking is a distinctive category that requires separate recognition. It can flow from causes quite apart from a disordered biology, for example, from something as simple as a desire to do harm. The fact is that these often social motives, and not just body chemistry, must be independently investigated.

Interestingly, moral problems are not usually perceived as such by those who perpetrate them. As rule breakers, the difficulties they create are largely visited upon others. It is these who find their behaviors objectionable and who wish them to change. In particular, it is not the distress of the troublemaker, but that of his or her role partners that they wish to diminish. The appropriate solution to moral problems may, therefore, be *social control*. The central goal is then to extinguish immoral behaviors, not to make the perpetrator feel better. Pills that reduce guilt would thus be counterproductive. Quite the contrary, "bad guys" must be made to desist from their mischief whether or not they wish to. Such help as is rendered is primarily to the victim, not the wrongdoer.

C) In the next sort of problem, the focus returns to the person experiencing distress. As we all know, things go wrong in life. Marriages fall

apart and houses are destroyed by hurricanes. Children may not grow up as their parents would like, while at work many people fail to achieve their most cherished aspirations. In general, we human beings confront two sorts of *problems in living* (Szasz 1961). The first may be considered *normal* problems. Because life is hard, we are all subject to relationship difficulties and are all buffeted by the demands of maturation. These often hurt and at times can be so severe that people cannot cope on their own. This is when they become problems. The second sort of difficulty in living is the *abnormal*, that is, the catastrophic problem. Not everyone suffers the trauma of war or the heartache of a severely disabled child, and yet, for those who do, the pain can be excruciating. When such crises arrive, they may understandably crumble. At such moments, they may cry out for help.

Naturally, those who are burdened by problems in living want to survive, and, if possible, prevail. Therefore, when their own resources prove inadequate, they can benefit from *social support* (Frank 1973). Sometimes hand-holding goes a long way. A positive social relationship can give people the courage to endure. Most of us know how comforting it is to be understood and are grateful when valued others refuse to abandon us during the hard times. We become stronger when their strength is transferred to us. This may not seem like much to outsiders, but the beneficiaries recognize that these contributions can be pivotal.

Likewise, people are helped when they receive assistance in solving specific problems. It should not be surprising that when something is broken, fixing it can be the answer. In consequence, the best response to a life problem can be *problem-solving*. If a person loses a job, getting a new one relieves distress; if a relationship deteriorates, correcting or replacing it can be the appropriate tonic. Achieving goals is wonderfully therapeutic. Although this is not always possible, helpers who facilitate it are invaluable.

D) The last type of individual problem, namely the *role problem* (Fein 1990), is often conflated with problems in living. Yet there are profound differences. The latter sort of predicament seems to happen to us. Neither normal, nor abnormal, difficulties in living seem to be the fault of the victim. As we all know, the world has rhythms that are beyond individual control. When fate chooses a target, the casualty may be blameless but hurt nevertheless. Role problems, in contrast, have an internal locus of control. They arise because of a person's own actions, not those of the outside world. An example may help. Suppose a person loses a job because he has a conflict with his boss. It may be that the boss is an obnoxious person or that their respective personalities do not jibe. In either case, the victim is merely unlucky. If, however, the person gets a new job, then finds himself embroiled in a similar conflict, the odds are that he has generated his own troubles.

Role problems can be distinguished from others by their repetitive character (Freud 1953-74). They are recapitulated endlessly with only slight modifications in a plethora of varying circumstances. People seem to develop ways of behaving that they reenact regardless of their surroundings. If these patterns are beneficial, their sponsors prosper, but if they are not, they carry around their personal dark clouds. Hence, those who are raised in abusive relationships may later in life seek out equally abusive partners. Again and again, they will find themselves cheated, betrayed, or ignored. When they do, despite having authored their own misfortune, it will hurt - often very badly. Role problems may be under a person's control, but when they are operative, they do not feel that way to the victim.

In the case of role problems, the appropriate solution is not merely enduring, but changing the offending patterns of interaction. It is not sufficient to extricate oneself from a bad situation if one has a tendency to recreate it elsewhere. What must happen is for a person's internal motives to be rearranged. Old role relationships have to be abandoned, and new ones introduced in their stead. This process has a recognizable course. Indeed, it has a name. It is called *resocialization.* It may also be referred to as *role change.* Generally, this mechanism constitutes the basis of what is referred to as psychotherapy. In this guise, it is typically thought of as pertaining to the individual. Nonetheless, a social perspective makes it plain that dysfunctional roles are generated in social interaction. Usually, they are created in coercive relationships and can be corrected only in a social settings that reverse these constraints. There is not the space here to describe the process in its entirety, but it entails a) reexperiencing painful roles, b) relinquishing the role scripts that hold them in place, and, finally, c) renegotiating superior replacements. Unless all three are achieved, dysfunctional patterns tend to resurface at the most inopportune moments.

To recapitulate, these four areas of application together cover a great deal of the clinical terrain. Distinguishing between them makes it apparent that not all discomfort has the same origin. Personal unhappiness may seem to be uniform, but understanding the diversity of its sources is essential. This, however, is possible only for those who clearly apprehend the social causes and consequences involved.

Modes of Intervention

Specifically sociological approaches to solving socially generated problems are legion. Once again, it is impossible to discuss them all, but a representative sample demonstrates how an interpersonal perspective enlarges the repertoire available to the individually oriented clinician. The techniques that follow can be applied to each of the problem areas presented above. How, and in what measure, will, however, vary with the problem and its

context. Some modalities, like social support, are broadly applicable, while others, such as role change, have a more limited relevance. Deciding which is likely to be most useful is itself part of a clinician's professional expertise.

Social Support. Not just problems in living, but medical, moral, and role problems all benefit from social support. People in distress often flounder because their problems terrify them. Whether the source of their fear is a physiological condition or a self-generated relationship, they race headlong into further suffering because they are too frightened even to perceive the springs of their distress. As a consequence, social reassurance can have a very general utility. Often people forget that therapeutic interventions are inherently social. Fundamental to all sorts of professional help is that which flows from the nature of a positive relationship.

Nevertheless, useful support is difficult to provide. It can be uncomfortable to be with someone who is suffering and challenging to supply such a person with the assurance he requires. This is where a sociological background can come in handy. By understanding the social roots of a client's terrors, a sociological practitioner can increase the chances of being reliably supportive. Social solidarity is not merely a matter of good intentions, but of appropriate communications and insightful validation. For instance, a well-meaning helper may assume that assuring a person that his reactions are normal is always sound. If, however, they are not, this assertion can prove disastrous. It may convince the client not that the helper is supportive, but that she is manipulative. For a validation to be believed, it needs to reinforce what is true. Otherwise, it will seem insincere. Sociology, of course, is an excellent vehicle for determining what is actually true.

An example of a valid supportive intervention is found in the work of Sarah Brabant (1996). She has developed considerable expertise in the management of grief. When people experience extreme losses, their reactions can be excessive and difficult to overcome on their own. They can undergo a depression so debilitating that it is literally life threatening. Brabant addresses this difficulty by recognizing the gap torn in a person's world by such a loss. Utilizing the analogy of a torn fabric, she guides her clients in mending that which has been ripped asunder. Her firm, but socially informed, support, enables them to gather the strength they need to persevere on their own.

A less obvious area in which socially sensitive support is useful is mental health. Those suffering from mental disorders almost automatically find their social relationships placed under stress. Their behaviors and emotional reactions can seem so odd, and/or demanding, that they are off-putting to their role partners. Those suffering from a bipolar disorder, for instance, can experience mood swings so extreme that those in contact with them do not know how to react, instead of being supportive, the latter may demand changes which make it even more difficult for the victim to cope. The work

of Beverley Cuthbertson Johnson (Cuthbertson Johnson and Gagan 1993) has addressed this dilemma in a number of ways. One of the techniques she has pioneered is guiding family groups in providing emotional sustenance for those with this particular malady. By helping these intermediaries understand why their loved ones behave as they do, she brings about social adjustments that serve to make life easier for all concerned.

Socialization. Often successful problem-solving, but also moral living, depends upon the possession of relevant skills. A woman may want to be a wonderful mother, but not know how to discipline her child, or a man seek professional success, yet misunderstand the nature of organizational politics. In either event, their good intentions may be impossible to implement. Social sciences such as psychology tend to imply that interpersonal skills can be automatically acquired by those who desire them. As a result, they concentrate on altering the cognitions or emotions they regard as causative and tend to neglect social learning. The truth is, however, that learning skills often entails complicated interpersonal understandings. For instance, in order to navigate complex organizations, one can benefit from recognizing their hierarchical nature. Bureaucracies possess an inner logic that is opaque to those who are naive about their operations. Likewise, families are not just collections of related people. They too possess dynamics that may not be immediately obvious. Because sociology has at its foundation the study of phenomena such as family interactions, social class disparities, and organizational structures, it is ideally suited to teaching real-world skills. Non-sociologists may mistakenly dismiss these as common sense, but they do so at their peril. A failure to recognize the implications of cultural, or structural, factors is a strong predictor of ineffectual conduct.

On a general level, Janet Mancini Billson (1994) has pointed out that understanding the social life of people, including those grappling with personal problems, entails understanding the web of interpersonal communications in which they are enmeshed. Because we human beings are symbol users, it is imperative to recognize the symbolic interactions that surround us. Furthermore, because society and self are inseparable, it is impossible to understand individuals without understanding the socially derived concepts with which they define themselves. Thus, helping clients to perceive their symbolic activities can facilitate an ability to perceive who they are and what they might choose to do differently in their lives. It can, therefore, convert them into persons who have control over their own destinies.

Resocialization Counseling. Resocialization is not just a form of personal change; it is also a mode of facilitating such change (Fein 1990; Fein 1992). Replacing distressing roles can be both a lengthy and painful process. Relinquishing and supplanting dysfunctional interpersonal patterns is

inherently stressful and inevitably protracted. Competence in facilitating it is, therefore, hard to achieve, and doubly so for those who do not recognize its overall structure. Because other disciplines concentrate on isolated feelings and disembodied cognitions, they tend to miss the natural personal, and interpersonal, sequences that are involved. Instead of recognizing that a protest phase may be heralded by a resistance to role loss, or that a period of profound sadness can indicate the severing of role ties, they prefer to describe unconnected anxieties and irrational depressions. Without a role context, the bits and pieces of resocialization seem distinct and senseless. In consequence, traditional therapists, rather than expedite the process, often impede it. As significantly, a social overview is essential to enabling clients to understand and determine their own fate. Resocialization is not magic and need not be mysterious. Once the victims of role dysfunction recognize why they are in distress and how they can escape it, they need not defer to medical or psychological authorities. Instead, they can assume responsibility for their own growth.

Conscious efforts at resocialization involve the three phases mentioned earlier (Fein 1990). The first entails identifying and re-experiencing the role problems in which a person is trapped. Since these roles are invariably painful, most people prefer to suppress them. Nevertheless change cannot occur unless their efforts at denial are attacked and breached. Being able to feel the terror of coerced behaviors, or the anger of lingering frustrations, is vital to being able to fix what has gone wrong. All too often people fail to improve their situation because they are trapped in fighting old battles in the same old way.

The second stage in resocialization requires a person to relinquish roles that are broken. Before a person can replace dysfunctional patterns, they must be set aside. This, however, is more difficult than might at first blush appear. Because it typically involves a substantial loss, a period of intense grief is required. This is the *sine qua non* for breaking attachments to that which is no longer viable. But such grief can be devastating. It can almost feel like death. As a consequence, navigating it without doing additional damage often demands the assistance of a skilled escort. The sociologically informed clinician can be such a cicerone if he/she is familiar with the underlying process.

Lastly, new and more satisfying roles can be substituted for those that are lost. This, however, entails the construction of fresh interpersonal behaviors. Non-sociologists often overlook the fact that social roles are negotiated affairs. They assume that people can simply be what they like without having to work through their parts with role partners. Were people social isolates, this might be true, but because what we require is the cooperation of others, a process of demand and counter-demand is necessary before the parties can agree to

patterns in which they both participate. Engaging in this give-and-take competently is essential to arriving at mutually gratifying arrangements.

Emotional Competence. For some reason, emotions often seem aberrant. As common as they are, people seem to imagine that they merely happen. It is as if their feelings occurred inside them, but in places that cannot be touched. Most people do not seem to realize that in order to be effective, feelings must be socialized (Lewis and Saarni 1985; Goleman 1995). They do not recognize that a major part of becoming an adult is learning to harness the communication and motivation functions of their feelings so that they can achieve the goals that emotions alone give us the power to accomplish.

Emotions, however, are not thoughts; nor are they asocial. They are an instrumentality unto themselves, which must be understood and dealt with on their own terms. As a crucial element in our internal machinery, they enable us to perform essential interpersonal tasks. Their energy and persistence have no substitute when it comes to influencing the social environment. As a result, mature adults would be wise to learn how to control their passions so that they can be used to achieve vital ends. Only then will it be possible for them to engage in truly successful human relationships. Only then can they engage in fully moral actions or initiate significant personal change.

Daniel Goleman has misleadingly recommended what he calls EQ, that is, emotional intelligence. Yet were this concept relabeled "emotional maturity," it would fit quite nicely with the social needs of those suffering from personal problems. As Goleman has noted (1995), in order to be successful in life, people need to be able to 1) understand their emotions, 2) manage their emotions, 3) motivate themselves, 4) recognize the emotions of others, and 5) handle the emotional aspects of relationships. It is the combination of these skills that enables them to avoid the misunderstandings and conflicts that result from ignoring the emotional dimensions of their behaviors.

Of particular import to those struggling with personal problems is an ability to cope with intense emotions. When feelings like anger and fear go out of control, they can wreck havoc. A sociologically informed program like IAM (Integrated Anger Management) (Fein 1993) enables people to take a step by step approach to overcoming their rage or terror. By recognizing that emotions are social phenomena, it can help them a) achieve physical safety, b) develop incremental tolerance to their feelings, c) evaluate what they are doing and with what effect, d) relinquish what does not work, and e) use their emotions to achieve what is vitally important.

Moral Competence. It has been more than a century since Emile Durkheim (1961) taught us that moral rules are socially constructed. Nevertheless most people still seem to believe they are non-natural facts that are either known or not known. Few people recognize that their values are, in large part, within their own control. They do not comprehend that the rules to

which they commit themselves are socially negotiated and emotionally enforced. This means that they can assume responsibility for their own moral development, if they so choose. It is, in fact, up to them whether they will be morally competent.

In most areas of human distress misplaced values play a vital role. Their part in moral difficulties is obvious, but many problems in living, and role problems, are exacerbated by the retention of outworn moral allegiances. Inappropriate guilt or shame can trap people in behavioral patterns that are inimical to their interests. The first step in solving these difficulties may therefore be to examine and overhaul their values systems. Otherwise, people can sabotage their own needs, as well as those of their peers. Instead of committing themselves to rules that have positive consequences, they battle each other with undue ferocity, inflicting grievous damage on others, while having the same visited upon themselves. In this case, they will be morally inept, the inventors of their own problems in living and the creators of their own vapid social roles. In order to avoid such an eventuality, people need to understand the social nature of morality, recognize their place in the process, and acquire the strengths needed to change what must be changed.

Again to allude to my own work, familiarity with the negotiation/emotion paradigm (NEP) (Fein 1997) makes it possible to escape a wealth of moral abuses and manipulations. Ironically, because morality is supposed to be pure, people may not recognize when it is used to create gratuitous pain. They may not understand, for instance, that. morality's dialectical character fosters polarized negotiations in which a good-guy/bad-guy mentality can rob the participants of their desire to be fair. Instead of listening to each other's point of view, they cease paying attention on the assumption that whatever a bad guy says must be wrong and is probably corrupting. This, however, can breed excesses and rigidities from which all will suffer. Without a conscious understanding of what one is doing, morality stops being a guardian and becomes a source of ill in its own right.

Conclusion

All in all, sociology can play a crucial role in serving the needs of the individual client. This is not to detract from the discipline's contributions to correcting the dysfunctions found in social institutions and organizations. It is a call for expanding the field's recognized area of application. We human beings are, and always will be, social creatures. We may sometimes appear to be isolated from one another, but we are never completely alone. Any attempt to render help that treats people as merely biological or psychological is therefore doomed. Likewise, social solutions that deny our separate humanity fare no better. *In truth, we are individuals, but individuals in a social context.*

Neither we, nor our potential clients, can afford to neglect so powerful an insight for doing social good.

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