

1-1-1988

Resocialization: A Neglected Paradigm

Melvyn L. Fein

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

Recommended Citation

Fein, Melvyn L. (1988) "Resocialization: A Neglected Paradigm," *Clinical Sociology Review*: Vol. 6: Iss. 1, Article 14.
Available at: <http://digitalcommons.wayne.edu/csr/vol6/iss1/14>

This Article is brought to you for free and open access by DigitalCommons@WayneState. It has been accepted for inclusion in Clinical Sociology Review by an authorized administrator of DigitalCommons@WayneState.

Resocialization: A Neglected Paradigm

Melvyn L. Fein

ABSTRACT

The micro clinical sociologist is better understood as being a social role change agent than as a "counselor" or a "therapist." Many of the personal problems which clients bring to clinicians are the result of dysfunctional social roles. These clients are best helped by "Resocialization," that is, by the alteration or replacement of their failed roles. This can be accomplished by a) reexperiencing the failed roles, b) letting go of them, and c) renegotiating new, more satisfying roles.

The micro clinical sociologist is confronted with a dilemma. How is he/she to characterize his/her work? One-to-one problem solving has traditionally been labeled either "therapy" or "counseling," yet neither of these appellations accurately describes the kind of work the micro clinician is apt to be doing.

In fact, the clinician will usually be working to solve "role" problems. His/her job will be to help clients change dysfunctional social roles into more satisfying ones. The goal of their mutual efforts will be "role change," in other words, "Resocialization."

The derivation of the word "therapy," in contrast, is from the Greek, meaning "to cure" or "to nurse" (McKechnie, 1971). It is essentially a medical term and implies that the person being treated has a "disease." But a person with "problems in living" (Szasz, 1961) does not ipso facto have a disease (Bettleheim, 1983). He (or she) may be depressed, or anxious, or confused, and still not be "sick."

The clinician is not merely "counseling" his client. Counseling implies giving "advice" (McKechnie, 1971), while the clinical sociologist is likely to be doing much more. Advice is only part of the process of helping a person overcome role problems; the professional is also helping the client to change failed social roles. Facilitating this process of change is a service in its own right and deserves, as such, to be taken seriously.

Role Change

The client who comes for professional counseling will be in pain. He (or she) will feel trapped and demoralized (Frank, 1973). He will probably not know why he is feeling as he is, but will be troubled by the fact that he cannot seem to make himself feel better. In all likelihood, this client will be suffering from the effects of role failure. He will be acting out social roles which fail to meet his personal needs, and will be feeling the pain of this deficit.

Social roles are the mechanism through which people interact with others. They are the scaffolding of personal relationships and provide the rules for interpersonal behavior (Linton, 1936; Turner, 1978). Without them, social life would be chaotic and virtually impossible. Indeed, viable relationships are essential for a livable life (Sullivan, 1953). Peoples most vital needs can only be satisfied in social interaction, especially their need for love, respect and safety (Maslow, 1954). The person trapped in failed social roles will therefore need to change these roles if he is to feel better.

The notion that role failure is the cause of much personal misery is not new. Roy Grinker (1961) has attributed neuroses to "disruptions in interpersonal relations." He suggests that breakdowns in "role complementarity" are at the root of many personal anxieties and disappointments. Jerome Frank (1973) similarly talks about the "maladaptive responses" people make. He explains that the inter and intra personal conflicts of childhood can erupt into adult life, and when they do, can interfere with a person's ability to meet his needs. Since Frank's "maladapted responses" are a form of failed role behavior, he is really reporting the same phenomena as described by Grinker.

Gerald Klerman (1984) has recently done much to highlight the significance of role problems. The widespread acceptance of his "interpersonal psychotherapy" for the treatment of depression has focused attention on role disputes and role transition difficulties. He and his colleagues have made it more fashionable to acknowledge the part role failure plays in generating individual pain.

Despite these insights, most of the professional literature talks not about role change, but about personality change. In doing so, many authors have made a mistake in emphasis. They have confused a part with the whole. While a person's role structure is indeed part of his personality (Lewin, 1935, 1951), it is not the whole of it. Temperament, cognitive style and innate reaction patterns are also parts of personality. These, however, seem to have a genetic basis (Chess and Thomas, 1986) and are not readily subject to alteration. It is the role structure, and not the entire personality, which professional intervention can hope to alter.

Role vs Self

Some professionals have objected to talk of "role change" because they have deemed social roles to be "artificial" (Goldberg, 1980). They prefer to talk about changing the "self" and what goes on inside the person, including his unconscious. But social roles are a core part of the self. They underlie personal identity (Babad et al., 1983) and are, indeed, a highly problematic part of the self. They are the part of self which, when it goes wrong, needs to be corrected.

One must understand that social roles can be very personal and very real, or very impersonal and artificial (Zurcher, 1983); it is the former which causes the most trouble and which costs the most travail to change. It is what Stryker (1968, 1980, 1985) calls "trans-situational" roles, that is, roles which are not tied to a particular social situation, and which cause the most intractable dilemmas. Roles such as the "shy one," "the family idiot," or "caretaker" can be a central and troubling part of a person's self.

These roles are usually family generated—almost always in childhood—and may include patterns such as "the scapegoat," "the macho-man," "the dreamer," "the wounded bird" and "the family hero" (Scarf, 1987; Wegscheider-Cruse, 1980). They contrast markedly with the more structure bound and generally less problematic, secondary-group roles such as "banker," "pedestrian" or "vice-president."

On the other hand there is no contradiction in considering personal roles to have an unconscious aspect. These roles are so taken for granted that they are often invisible to the person living them. Hence, they usually need to be made explicit before they can be altered.

The concept of "role change" has the advantage over "personality change" or "self change" of being both an inter and an intra personal concept. Roles are something that happen both within and between people. A role may be enacted by an individual, but this is always within a social context. Furthermore, a person's roles are always developed in interaction with others (Wenworth, 1980).

Roles are negotiated products (Turner, 1978). They are the result of the bargaining which continuously occurs within human relationships. Their origin is in the everyday dialogues which take place between parent and child, husband and wife, boss and worker (Nye, 1976; Garbarino et al., 1986; Strauss, 1978). It is these demands and counterdemands which people make of one another that form the very stuff of real life through which persons generate a sense of who they are (Mead, 1934); Cooley, 1956).

Roles, and therefore, role problems have their genesis in interpersonal relations. They are truly psycho-social phenomena, and are, therefore, the proper level of analysis when helping people to cope with their personal difficulties.

Resocialization

Socialization is the process whereby people acquire social roles, and, therefore, resocialization is the process whereby failed social roles are altered or replaced. Resocialization implies the pre-existence of some social roles which must be superceded or changed. If a person can improve his life situation by merely adding new roles, he is engaged in "adult socialization" (Brim and Wheeler, 1966), not resocialization.

Very often, positive change cannot occur without deactivating old social roles. Most adult roles are built upon earlier, more basic, role structures, which must be changed or dropped before new structures can be constructed. The residue of interpersonal behavior patterns acquired in childhood therefore need to be addressed or they will continue to assert themselves and to disrupt any new patterns which are attempted.

The *Encyclopedia of Sociology* (Dushkin Pub., 1973) says that resocialization "involves abandonment of one way of life for another that is not only different from the former, but also incompatible with it." It describes this process as both radical and rapid, yet the replacement of failed social roles is one of the most difficult and protracted of all human endeavors. Old roles are not relinquished merely because they have become dysfunctional, or because the social sanctions which once sustained them have been altered (Riley et al., 1969). People hold on to basic social roles, especially those which have been developed in childhood, with a tenacity that can be remarkable (Papp, 1983). Freud (1920) has aptly described this phenomenon as "resistance." It is almost as if people fear that they will die if they let go of a failed role.

To be sure, not all of the help provided by sociologists or psychotherapists is resocialization. Not all pain is caused by role failure and not all change requires role replacement. Sometimes persons in pain only require "support" so that they can solve their own problems (Fein, 1987b); and sometimes they only need "socialization" (e.g., skill acquisition) (Cotter and Guerra, 1976) so they can construct more satisfying life patterns. Nevertheless, "resocialization" is, to an extraordinary degree, the intervention of choice for people in pain and needs to be recognized as such.

Loss and Losing

Kubler-Ross (1969) has made us aware that there are stages people go through when they are dying or coping with the death of others. John Bowlby (1969, 1973, 1980) has shown how these stages apply to other loss processes as well. Typically, when a person encounters a grievous loss, e.g., of life, he/she initially (1) denies the loss, (2) protests against it, and (3) withdraws into

a deep sadness. Only when this sadness has been worked through is the person ready to (4) reemerge into the mainstream of life.

When first confronted with death, people are usually too afraid to openly acknowledge it. As a security measure, they may pretend it has not happened. When, in time, it dawns on them that it has happened, they will be able to get angry at the prospect of loss, and try to prevent it. Eventually, as it becomes plain that loss cannot be avoided, they will also be able to become depressed. This depression, which is so strenuously resisted, is ultimately what allows them to let go of what is lost, and accept the possibility of new attachments.

Bowlby has shown that this loss process applies not only to death, but to separation as well. In fact, this process also occurs in the loss of social roles. When someone dies and we grieve for them, we are mourning not only the loss of their person, but our relationship with them as well. Since it is through our social roles that we relate to others, when we lose a role (even a bad one), it is very much like losing a person. Weis (1975) has shown that this occurs during divorce, and Brown and Harris (1978) have shown that it occurs with social stratification losses.

When social roles fail, and there is a need to let go of them, people may resist doing so. They may deny that something has gone wrong or may actively engage in trying to restore what is lost; thus, when they come to a clinician for help, their denials and protests may prevent them from knowing why they are in pain. All they may know is that they are confused, fearful, angry, or hurting. Yet these states, which are commonly described as "problems," are in reality stages of the role loss process.

Furthermore, when people engage in unsuccessful role negotiations, that is, when their negotiations don't lead to satisfying role relationships, they, too, experience a loss. Losing a role negotiation may be equivalent to the loss of an established role (Szasz, 1961). In both cases, a role is gone and cannot be retrieved; the more intense the losing, the more painful the loss.

Role negotiations which are excessively coercive, or which involve outright neglect, almost never permit the establishment of roles which meet personal needs (Garbarino et al., 1986). They do not by definition, allow voluntary, mutually agreed upon bargains to emerge. They impose solutions upon one of the parties, and what is imposed does not satisfy; it is resisted. In coercive role negotiations, the unequal power of one is used to prevent the other from getting what he may desperately want. The other finds that no matter what he does, he can't get his way; in short, he loses. Whether an existing relationship is torn asunder, or an embryonic relationship dies aborning, should a serious loss occur, it must be then mourned before new roles can be developed.

The Change Process

Resocialization entails letting go of failed or aborted social roles and replacing them with more satisfying roles (Fenichel, 1941). This role change occurs in three essential stages. The process is roughly as follows:

1. *Experiencing (or Reexperiencing) the Failed or Aborted Role.* Before a role can be altered or replaced, it must be activated (Greenberg and Safran, 1987). The thoughts, feelings and plans which guide role behavior must be made real before change can take place. It is not enough to recall what has gone wrong. The role itself must come back, for only then can its internalized scaffolding be rearranged. It is as if appropriate circuits in the brain must be turned on before they can be reorganized. Freud (1924) was aware of this when he discussed the "repetition compulsion," as was Alexander (1948) when he spoke of the "corrective emotional experience."

2. *Letting Go.* When a failed or aborted role has been experienced, at least part of it must then be relinquished. The role, or part of it, must be allowed to die; what is lost must be then mourned as must any major loss.

Letting go is not easy, however. Just as with mourning the loss of a loved one, a person may resist change. Denial, protests and anxiety may slow, or halt, the process of role replacement. The more basic the role to be replaced, the more difficult it will be to release it. Roles which are acquired early in life, and/or which are deeply integrated into other complexes of roles represent serious losses. It is, therefore, with considerable reluctance that people accede to their demise.

In particular, the mechanisms which hold social roles in place will have to be addressed and altered. If social roles are thought of as having scripts composed of a) cognitive, b) emotional, c) volitional and d) social components, then their dysfunctional elements will have to be searched out and changed (Wolberg, 1967; Allport, 1985; Fein, 1987a). If, for instance, a person's role behavior is being guided by an irrational self image; or if intense sadness and fear are preventing his mourning unsatisfying patterns; or if perverted values, or uncooperative role partners discourage change; then these ideas, feelings, values and role partners may have to be modified before the dysfunctional role they are maintaining can be relinquished.

3. *Renegotiating New Roles.* Once failed roles have been relinquished, the person undergoing change will feel adrift. The old ways of doing things and the old ways of relating to people will be gone. The person will still need to have his/her needs met, but the role repertoire with which to accomplish this will have been diminished. It will, therefore, be necessary for the person to negotiate new roles. Because some parts of the old roles will still be present, it is perhaps more accurate to describe this as "re-negotiation."

In any event, this negotiating will be done with other people. Roles, includ-

ing new roles, are always developed in conjunction with others. The person with role problems cannot solve them in isolation. If he/she is to construct a more satisfying life situation, it will be necessary for him/her to engage in a fair negotiation with another human being. Since it is non-coercive, mutually responsive negotiations which foster the construction of satisfying roles, they must be encouraged and secured.

Resocialization in Practice

The clinical sociologist, or any role change agent, must be cognizant of the structure of the role change process. If change is to be effectively facilitated, the clinician must know what he or she is attempting to do. Nevertheless yet the outline of resocialization which has been presented above may make the process seem too easy. The steps of 1) experiencing the failed role, 2) letting go of it, and 3) renegotiating new and more satisfying roles may sound automatic, but in practice they are surely not.

A resocializer is engaged in a difficult, amorphous and uncertain business. Neither he/she nor the client may know a) precisely how to identify failed roles, b) exactly what it is which is impeding their alteration, and c) what a preferable alternative role might be. Moreover, since resocialization occurs within a relationship, the change agent will be "on the line" as a person. Resocialization is not an academic exercise, and its effective resolution depends largely upon the clinician's knowledge, courage and personal integrity. He/she must be a skillful and bold technician who is familiar with the methods which facilitate role change and who has the personal qualities to implement them.

Many of the specific change techniques which the clinical sociologist may choose to employ in fostering resocialization have been extensively explored by psychologists, social workers and physicians. Methods such as the analysis of transference and counter-transference (Fine, 1979) are directly applicable to the analysis of role failure, as are the contributions of cognitive psychologists, such as Aaron Beck (1976). His studies of "automatic thoughts" have shed much light on the cognitive impediments to role change and how they can be removed. Similarly, Dean Pruitt's discussions of the "dual concern" model of negotiations (1981) are directly relevant to understanding how roles are negotiated and renegotiated. His notion that a successful bargain depends upon taking account of the interests of both parties and then problem-solving to find creative ways of maximizing both, says much about how roles which meet needs can be constructed.

The practice of resocialization is inordinately complex and a short article cannot begin to do justice to its intricacies (Fein, 1987b). The literature on counseling and psychotherapy is enormous and is filled with many insights which have barely been touched upon here. One of the vital tasks upon which

clinical sociologists can embark is therefore, coordinating the knowledge of psychology and sociology, and placing both within the context of the resocialization paradigm.

A Case Study:

Robert

Much of the preceding has been highly abstract and, therefore, may leave the reader who has not had personal experience with resocialization wondering about the realities of the process. Since a concrete example can often bring the abstract to life, a brief case study is in order. The following is from the author's practice and is a drastic abridgement of several year's work.

When Robert (as we will call him) originally came for therapeutic help, he was already a man in his early 50s. He had a long history of alcoholism, and had been sober for three years. Yet Robert was not happy and this troubled him. Friends in Alcoholics Anonymous thought that sobriety itself should bring contentment, but Robert found that, for him, this was not so. He still felt himself to be a "failure" and a "coward," and worried if he would ever be able to feel good.

He and his resocializer set about exploring the nature of Robert's failed roles. One of the first of these with which they grappled was that of "coward." It seemed that Robert had been raised by a brutal and authoritarian father who constantly threatened him with physical harm. When Robert withdrew to protect himself, he was promptly labeled a coward and berated for his weakness. Since Robert was quite aware of the terror his father inspired in him, he was sure his father was correct.

As an adult, he felt the same way, and he still withdrew from situations he was perfectly competent to handle. During the resocialization process, Robert was encouraged to reexperience the intimidation he had received at his father's hands. The clinician, by engaging in "role taking" (Mead, 1934), was able to gain an understanding of what Robert had been subjected to as a child, and then to reflect this back to him in the present (Rogers, 1951). The revivification of old feelings and thoughts which this stimulated made it possible for both of them to deal directly with Robert's fears of his father. By reliving these fears in a safer environment, Robert was able to become less frightened. It became possible for him to distinguish past realities from present relationships. He could see and feel where his role of "coward" came from, and so he was better prepared to relinquish it.

Much to his surprise, as he came to understand where his fears originated, the more pained he felt. His anger at his father rose and his desire to defeat him increased geometrically. Since his father was no longer alive, he could not

literally refight his lost battles, but he could engage in role plays with the clinician and with his friends at AA, using them as surrogates for Dad. In this way he might hope to "redo" the past and achieve "shadow victories" over his father.

The anger and fear Robert experienced during these role plays was very like the anger and fear he had experienced when his father had actually attacked him, but now he was an adult and better able to defend himself. No longer was he literally losing and no longer was he literally in danger. Soon the intense anger he felt toward his father did not have the same point. It was no longer a necessary defense against losing. In time, he came to appreciate that what was past was indeed past; and that what was lost was lost. He might not like it, but the love, concern and protection which he still craved from his father were not to be. If he wanted these needs fulfilled in the present, he would have to get his satisfactions either from other people or from himself.

This realization ultimately left Robert very sad. He began to mourn the terrible relationship he had had with his father. It became clear that the persecution he had undergone had not been necessary. What he received was not fair punishment for something inherently wrong in him, but was a result of his father's own weaknesses. This made the love and protection he never received hurt all the more. Tears would well up in his eyes as he would relate the agony of his aloneness to the clinician. "Do you think I still miss the love I didn't get?," he would ask. Then he would cry.

Yet when this sadness too began to lessen, Robert was ready to move on. He started to feel more an independent person and less an extension of his father's will. Gradually the courage which the clinician had been able to share with him when he was caught up in his fears and rage became his own courage. It became obvious, even to him, that he had survived a great deal in life, and that a person who had survived what he had must have some courage.

Robert slowly began to appreciate that having fears per se did not make him a coward. He saw that he didn't have to be another "John Wayne" in order to have courage. This gave him the confidence to negotiate new roles for himself. In fact, in AA he became able to assert a leadership role. Instead of automatically retreating whenever his colleagues disapproved of what he was doing, he learned to hold his ground. Rather than assume that these others must be right, he stopped to consider whether or not they were.

When he was in doubt, he went to the clinician and discussed matters with him. Then, he might say, "My friends are telling me 'Don't be that way!', but I think they're wrong." The clinician would then assume a mediator's role. His job would become to try to understand Robert's current negotiations. He might then explain to Robert what seemed to be going on, and what the alternatives were. It was then up to Robert to apply these insights to his interactions with role partners.

Though Robert found that his growing understanding did not prevent his friends from continuing to question the way he solved his personal problems, he discovered that he was increasingly able to withstand their criticisms and to assert his own perspective. He did, indeed, come to understand that in dealing with personal fears, he usually had more courage than his peers. Moreover, his coping strategies usually worked better than their's and as a result, much to his amazement, his role in the world began to change. His friends began to accord him a measure of leadership and respect. He and his opinions became valued, and so his position in the group changed. Robert even began to feel good about himself; and this he could scarcely credit.

Conclusion

The concept of resocialization has not been much used by either sociologists or psychologists. It is rarely discussed in the literature, and more rarely employed in planning intervention strategies. Role change agents often describe the work they do as psychosocial in nature, but then go on to describe it in medical or psychological language. Yet "Resocialization" is the more appropriate framework for what they do. It is a concept which bridges the gap between the psychological and the social. It puts people with problems in their proper context; that is, it allows the clinician to consider clients as human beings in the midst of other human beings.

Many of the problems in living with which people grapple are the result of unfortunate encounters with other human beings—usually early in life. Their pains are often sociogenic in nature, and their hope of improvement is also social in nature. Indeed, many psychotherapists have come to realize this (e.g., those concerned with "object relations") and so a convergence between psychology and sociology may be in progress.

More and more it is recognized that social roles are negotiated products; and that when they go wrong, they must be renegotiated. Because of his/her social perspective, the clinical sociologist is in a position to bring a special expertise to this process. He/she can utilize knowledge of how roles are formed and maintained, and of how they fail or are aborted, to aid others in constructing more a satisfying role repertoire. The recognition that much "counseling" and "psychotherapy" are really "resocialization," can, if put into practice, effect a substantial change in the way many human services are delivered.

REFERENCES

- Alexander, F.
1948 *Fundamentals of Psychoanalysis*. New York: W.W. Norton.

- Allport, G.
1985 The Historical Background of Social Psychology. In: Lindzey, G. and Aronson, E. (Eds), *Handbook of Social Psychology*; Third Edition. New York: Random House.
- Babad, E., Birnbaum, M. and Benne, K. (Eds.)
1983 *The Social Self: Group Influence on Personal Identity*. Beverly Hills: Sage Publications.
- Bazerman, M. and Lewicki, R. (Eds.)
1983 *Negotiating in Organizations*. Beverly Hills: Sage Publications.
- Beck, A.
1976 *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.
- Bettleheim, B.
1983 *Freud and Man's Soul*. New York; Knopf.
- Biddle, B.
1979 *Role Theory: Expectations, Identities and Behaviors*. New York: Academic Press.
- Blumer, H.
1969 *Symbolic Interaction: Perspective and Method*. Englewood Cliffs: Prentice-Hall.
- Bowlby, J.
1969 *Attachment*. New York: Basic Books.
- Bowlby, J.
1973 *Separation: Anxiety and Anger*. New York: Basic Books.
- Bowlby, J.
1980 *Loss: Sadness and Depression*. New York: Basic Books.
- Brim, O. and Wheeler, S.
1966 *Socialization after Childhood*. New York: John Wiley.
- Brown, G. and Harris, T.
1978 *Social Origins of Depression*. New York: Free Press.
- Chess, S. and Thomas, A.
1986 *Temperament in Clinical Practice*. New York: Guilford Press.
- Clausen, J. (Ed.)
1968 *Socialization and Society*. Boston: Little Brown.
- Cooley, C.H.
1956 *Human Nature and the Social Order*. Glencoe, Ill.: The Free Press.
- Cotter, S. and Guerra, J.
1976 *Assertion Training*. Chicago: Research Press.
- Dushkin Publishing.
1973 *Encyclopedia of Sociology*. Guildford Conn.
- Fein, M.
1987a *Dysfunctional Role Maintenance*. Paper presented at Sociological Practice Assn. annual meeting.
- Fein, M.
1987b *Resocialization: The Theory and Technique of Social Role Change*. Unpublished Manuscript.
- Fenichel, O.
1941 *Problems of Psychoanalytic Technique*. New York: Psychoanalytic Quarterly.
- Fine, R.
1979 *A History of Psychoanalysis*. New York: Columbia University Press.
- Frank, J.
1973 *Persuasion and Healing: a Comparative Study of Psychotherapy*. Baltimore: Johns Hopkins Press.

- Freud, A
1966 *The Ego and the Mechanisms of Defense*. New York: International Universities Press
- Freud, S
1924 *A General Introduction to Psychoanalysis*. New York: Simon and Schuster.
- Freud, S
1963 *Therapy and Technique*. New York: Collier Books.
- Garbarino, J., Schellenbach, C.J. and Sebes, J.
1986 *Troubled Youth, Troubled Families*. New York: Aldine De Gruyter.
- Glass, J.
1979 *Renewing an Old Profession*. *American Behavioral Scientist*, Vol. 22, No. 4.
- Goslin, D. (Ed.)
1969 *Handbook of Socialization Theory and Research*. Chicago: Rand McNally
- Goldberg, A. (Ed.)
1980 *Advances in Self Psychology*. New York: International Universities Press.
- Gove, W. (Ed.)
1982 *Deviance and Mental Illness*. Beverly Hills: Sage Publications.
- Greenberg, L. and Safran, J.
1987 *Emotion in Psychotherapy*. New York: Guilford Press
- Grinker, R.
1961 *A Transactional Model for Psychotherapy*. In: Stein, M. (Ed.), *Contemporary Psychotherapies*. New York: Free Press of Glencoe.
- Kennedy, D.B. and Kerber, A
1973 *Resocialization: An American Experiment*. New York: Behavioral Publications.
- Klerman, G L., Weissman, M.M., Rounsaville, B.J. and Chevron, E
1984 *Interpersonal Psychotherapy of Depression*. New York: Basic Books.
- Kubler-Ross, E
1969 *On Death and Dying*. New York: MacMillan.
- Lewin, K.
1935 *A Dynamic Theory of Personality*. New York: McGraw-Hill
- Lewin, K.
1951 *Field Theory in Social Science: Selected Theoretical Papers*. (Edited by D. Cartwright) Chicago: University of Chicago Press.
- Linton, R.
1936 *The Study of Man*. New York: Appleton-Century-Crofts.
- London, P
1964 *The Modes and Morals of Psychotherapy*. New York: Holt, Rinehart and Winston.
- Maslow, A
1954 *Motivation and Personality*. New York: Harper and Row.
- McKechnie, J. (Ed.)
1971 *Webster's New Twentieth Century Dictionary*. Cleveland: World Publishing.
- Mead, G H.
1934 *Mind, Self and Society*. Chicago: University of Chicago Press.
- Norcross, J.C. (Ed.)
1986 *Handbook of Eclectic Psychotherapy*. New York: Brunner/Mazel.
- Nye, F I.
1976 *Role Structure and the Analysis of the Family*. Beverly Hills: Sage Publications
- Papp, P
1983 *The Process of Change*. New York: Guilford Press.

- Pruitt, D.G.
1981 *Negotiation Behavior*. New York: Academic.
- Riley et al.
1969 *Socialization in the Middle and Later Years*. In: Goslin, D. (Ed.), *Handbook of Socialization Theory and Research*. Chicago: Rand McNally.
- Rogers, C.
1951 *Client Centered Therapy*. Boston: Houghton-Mifflin.
- Sarbin, T. and Allen, V.
1968 *Role Theory*. In: Lindzey, G. and Aronson, E. (Eds.), *Handbook of Social Psychology*. Mass.: Addison, Wesley.
- Scarf, M.
1987 *Intimate Partners: Patterns in Love and Marriage*. New York: Random House.
- Scheff, T.
1966 *Being Mentally Ill: A Sociological Theory*. Chicago: Aldine.
- Strauss, A.
1978 *Negotiations: Varieties, Contexts, Processes and Social Order*. San Francisco: Jossey-Bass.
- Stryker, S.
1968 *Identity Salience and Role Performance*. *J. of Marriage and Family*, 30, 558-564.
- Stryker, S.
1980 *Symbolic Interactionism*. Menlo Park, Ca.: Benjamin/Cummings.
- Stryker, S. and Statham, A.
1985 *Symbolic Interaction and Role Theory*. In: Lindzey, G. and Aronson, E. (Eds.), *Handbook of Social Psychology; Third Edition*. New York: Random House.
- Sullivan, H.S.
1953 *The Interpersonal Theory of Psychiatry*. New York: W.W. Norton.
- Szasz, T.
1961 *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Dell.
- Turner, R.H.
1978 *The Role and the Person*. *Amer. J. of Sociology*, 84, 1-23.
- Wegscheider-Cruse, S.
1980 *Another Chance: Hope and Health for Alcoholic Families*. Palo Alto, Ca.: Science and Behavior Books.
- Wentworth, W.
1980 *Context and Understanding: An Inquiry into Socialization Theory*. New York: Elsevier.
- Weiss, R.S.
1975 *Marital Separation*. New York: Basic Books.
- Wirth, L.
1931 *Clinical Sociology*. In: *Am. J. of Sociology*, Vol. 37.
- Wolberg, L.
1967 *The Technique of Psychotherapy*. New York: Grune and Stratton.
- Zurcher, L.
1983 *Social Roles: Conformity, Conflict and Creativity*. Beverly Hills: Sage Publications.