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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 dogmatism, 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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