Clinical Sociology Review

Volume 1 | Issue 1 Article 8

1-1-1982

Clinical Sociology on the One-to-One Level: A Social Behavioral Approach to Counseling

Roger A. Straus
Center for Clinical Sociology

CLINICAL SOCIOLOGY REVIEW, Vol. 1, 1982

Clinical Sociology on the One-to-One Level: A Social Behavioral Approach to Counseling[1]

Roger A. Straus
Director, Center for Clinical Sociology

Clinical sociology involves interventions for change at any or all levels of social organization, based upon and/or guided by sociological principles and perspectives (Straus, 1979a,b). Although sociologists are typically envisioned as working with groups, organizations, communities and other large social units, sociological social psychologists have, for some fifty years, demonstrated an interest in working with individuals and their intimate groups (Wirth, 1931).

In this paper, I examine the social behavioral approach to individual counseling which has evolved from my experience as a private practitioner working with problems of conduct, substance abuse, sexuality, interpersonal relationships, job and life stress, and the enhancement of personal performance generally. Discussion centers around this context of training subjects to use their own self-interactions strategically in order to overcome blockages and positively to maximize performance. Generically, however, I show how sociological social psychology can be translated into clinical practice, and the strategies of intervention appropriate to a social behavioral approach.

PRINCIPLES OF THE APPROACH

"Social behavioral" is, of course, drawn from the usage of G.H. Mead (1934), the pragmatist philosopher who founded what has become known as symbolic interactionism or the "Chicago School" of sociological social

psychology. I must caution the reader that translation of any intellectual perspective into clinical practice necessitates a degree of eclecticism. What follows, therefore, will not only draw upon Mead and his followers, but the fullest range of contemporary theory, practice and research on the part of social and behavioral scientists.

Three principles are central to this approach. First is that of *contextualism* (Sarbin, 1977), a philosophy of science quite unlike the mechanistic logic underlying conventional social and behavioral thinking. A contextualist focuses upon situations and performances within those situations, not upon "causes" or hidden determinants of behavior. The individual is seen to exist in a dialectical relationship with his/her social and material environment. Not only our conduct but our very sense of being a certain "self" is seen to reflect or internalize the social arrangements, culture, knowledge and economy of our human context. This view is often called the "social construction of reality" (Berger and Luckmann, 1967).

The second principle is *activism* (Lofland, 1976). The human is viewed as a creative, self-reflexive and relatively autonomous subject who does things, who *acts* more than passively responds to drives, forces or pressures as depicted, for example, by psychological behaviorism (Skinner, 1953).

While for many sociologists such as Goffman (1959) or Douglas (1976) this principle leads to a highly sceptical view of humans and their relationships, the clinician almost invariably couples his/her science with humanism. Our clients are seen as already doing the best they can to meet their conditions of existence and as trying to create a relatively stable, meaningful and satisfying life for themselves and those with whom they are closely bonded. The clinical task is not to diagnose and treat a patient's case but to assess a client's situation and then help that subject define and resolve blockages in his/her construction of action (Straus, 1977).

There is a very important practical aspect to this analysis: whatever we find people doing on a "things as normal" basis must make some manner of sense to them or they would be doing something else that does make sense. More than abstract, logical "sense", conduct displays some kind of practical, functional payoff. Even "crazy" people are not stupid; it is only that what they are doing or how they are doing it makes little or no sense from our perspective.

The inherent contradiction between the first two principles was long ago addressed by W.I. Thomas, who sought to resolve this problem by introducing the third principle, *definition of the situation* (1931). This holds that it is not

the actual situation which determines people's response but what they believe to be the actual case, how they *interpret* their situation.

Not, however, a private matter, definition of the situation represents the individual's interpretation of his/her situation based on the definitions of the situation which have been presented to him/her in interaction with others. Lying at the interface between organism and social context, we might consider the definition of the situation a form of dialectical synthesis between the streams of action occurring within the individual and within that individual's interpersonal environment.

The linkage between these two realms is *heterointeraction,* the process of verbal and nonverbal exchanges between two or more human individuals. Heterointeraction and social stratification are perhaps the basic subjects of the sociological discipline; however, sociologists have tended to focus almost entirely upon the flow of influence from members of the socially organized environment to the individual social actor.

It is not entirely appropriate to consider the social construction of *reality* (a person's total set of definitions or schemata for understanding self, world and others) a one-way flow. Sapir (1949) makes this point very clearly, as does common sense.

Interactionism depicts the process by which the individual selects and constructs his/her own acts as a quasi-verbal *self-interaction* in which the subject makes indications to his/her self (Blumer, 1969). The significance of "thinking" has largely been neglected by sociologists. However, recent psychological studies have stressed the practical signficance of self-interaction as a sort of counterpoise to heterointeractive determinism.

There is clearly more to self-interaction than just this quasi-verbal thinking process, however. As an increasing body of psychological findings suggests, humans interact with themselves on a more holistic basis than that.

Most important for our discussion here is the process of *imagining,* which Sarbin and Coe (1972) describe as muted, attenuated role-playing developmentally parallel to the child's internalization of language acts as "thinking." In constructing and acting-out entire scenarios on a hypothetical, "as if" basis, the person represents to him or herself all the qualities of an actual experience, not just intellectual abstractions. These include the subject's sensual apprehension of the object or scene being imagined, and also the person's affective, emotional, organismic and other nonrational responses. Thus the imagination represents the most complete definition of the situation available to the subject.

I have come to use the generic term *mindwork* to describe the class of counseling and performance-enhancing situations in which the subject employs strategies of thinking and imagining as the primary means to accomplish his or her goals. Such strategies inherently involve a social or at least a social-psychological component and are, therefore, within the potential methodological domain of the clinical sociologist.

There is increasing consensus, for example, that hypnotism is not simply the "trance state of hypersuggestibility" it has long been considered. Rather, hypnotic responses such as hallucination or "involuntary" physical and psychosomatic behaviors are produced by the *subject's own acts* of thinking and imagining along with "suggestions," definitions of the situation communicated by the hypnotist in the special social situation of the hypnosis session. The key to these responses is not being entranced, it turns out, but cooperating in that situation and enacting the social role of a "hypnotized subject" (Sarbin and Coe, 1972; Sarbin, 1977; Barber, 1979a).

Barber and other cognitive-behaviorists have suggested, as well, that we actively maintain our meanings and other realities within the 24-hour-a-day stream of background thinking. Not only do we build up our conduct by talking to ourselves, but through our self-interactions—characterized by Barber as "self-talk, and the associated feelings and images" (1979b: 111)—we also maintain the definitions of the situation upon which that conduct is organized.

SOCIAL BEHAVIORAL INTERVENTIONS

I employ intensive heterointeraction to guide the subject's reconstruction of realities within that stream of consciousness, and also to teach the client strategies for both managing these realities and more effectively dealing with the social and material worlds. This approach is common to practically all social behavioral and cognitive-behavioral interventions, although it is clearest in those employing hypnosis, imagery, biofeedback and other forms of mindwork. Even where the client seeks help in dealing with relationships or social circumstances, we generally begin with his/her own self-interactions as the first step toward resolving the objective situation.

Interventions following such principles may be direct or indirect. I have employed at least four direct strategies. One is simply providing the client with information and know-how. Another is to employ some form of mindwork to

reconstruct meanings the subject holds for objects or situations. Thirdly, reality reconstruction may be directed toward the more abstract level of the relationships and roles a client sees between his/her self and components of the situation. Fourth (Powers, 1979), I would help the client sort out his/her stated and unstated preferences or untangle contradictory definitions of the situation.

In addition to, or instead of the above, the sociologist might employ *indirect* strategies directed at the client's context more than his/her "content." I believe that Thomas' "beneficent reframing" approach (Wirth, 1931) was of this type. Other examples include networking, strengthening family or other primary relationships (Coombs, 1980), and training the client in practical means for dealing with problematic situations, objects and others.

In each case, the counselor is more clearly doing applied dramaturgy than conventional therapy. Such counseling roles are more creative, active and sometimes directive than most psychological counseling. At the same time, they represent direct extensions of the traditional eductional and research roles of the sociologist: the social behaviorist helps clients learn how they can do something about their situations, how they can more effectively change, choose or control their own acts and other performances in life.

The connection to "academic" sociologist becomes even clearer when we look at the pattern of the social behavioral process. It follows the typical pattern of "naturalistic" field research (Lofland, 1976). One first gathers information from which is generalized an *explanatory model* describing the client's situation in operational terms. However, the clinician does not stop with generating substantive theory but then proceeds to the actual intervention in which that model is used to organize appropriate actions to resolve that case. In other words, we create an hypothesis about the case and then translate it into clinical action.

Situationally, social behavioral work is no different from other counseling. One requires some kind of intake set-up in which a prospective client is screened, a contract agreed upon between client and provider (often in the form of an explicit "behavioral contract" of the sort now in general use), and the roles and rules of the counseling relationship established. Then sessions will be provided during which the counseling interventions will take place.

Unlike some counselors, however, sociologists like myself are committed to the principle of *minimal intervention.* We minimize the extent and duration of interventions, the degree to which the counselor takes or maintains an authoritarian role and, most particularly, the changes we demand our clients

make in their lifestyles, relationships or conduct. It is the client's right to determine what is acceptable, appropriate or desirable in terms of his/her own living. It is the counselor's task to help that person get on with the business of living in his/her own preferred style and manner.

Therefore, it is crucial that we not addict clients to our helping but rather get them over the need for help. In order to avoid problems of transference, mystification or exploitation of power disparities between client and sociologist (see Beilin, 1979), we direct counseling toward training clients in self-management and we train them in strategic practices which they can employ on their own to maintain case gain on the longest term (see Straus, 1977, 1979c).

Whether we organize the counseling, as I did, by offering the client a no cost consultation interview for purposes of intake and then provide a series of individual or group sessions, or establish some alternative program structure, our task falls into two parts. The first is that of *assessment* and the second that of *implementation.*

THE ASSESSMENT PHASE

Typically, assessment begins with the client intake process but, for more complex cases, may continue over several further sessions. This phase consists of gathering information through sociological field methods—primarily "intensive" interviewing (Lofland, 1976)—and then generalizing an explanatory model for the case. However, rather than preparing a written research report, the clinician summarizes and explains his/her findings to the client.

This is done in the manner of an *instrumental hypothesis* (Hurvitz, 1970). That is, the explanatory model is so organized as to describe the client's situation in a manner that defines and facilitates the possibility of change. "There is something wrong with your brain chemistry" is not of this form, while "You seem to be over-reacting to your boss' behavior" would be, since it establishes the possibility of changing one's reactions.

The assessment phase ends when the explanatory model is presented to the client and the client agrees that it fits his or her case. Often it is necessary to negotiate a mutually acceptable definition of the situation with the client, modifying one's original model.

Normally, the explanatory model is presented in logically backward fashion. Illustrating this point, I will describe the typical presentation for clients who want to stop overeating, as seen in my own private practice.

First, one's overall conclusions are stated in such a way as to begin the process of reframing the situation for the client. I would tell clients that they were not crazy, that there was nothing wrong with them. We would have to work together to change how they think about food and eating and to teach them some better ways of handling stress and coping with temptations.

Our clients *know* that there is something very seriously wrong with them. This belief is part of their problem. Some adopt pathological metaphors but most Americans stigmatize themselves in moral terms such as "I lack willpower." This explanatory scheme reflects the Puritan idolization of "self control" and resisting fleshly temptations, now institutionalized in middle-class culture.

In presenting the assessment we initiate clients' redefinition of their situations on a variety of levels, of which this self-stigmatization and the often associated sense of total frustration and inability to change are an integral part. At the same time, we are educating people to apply a relativistic social pespective to themselves.

Therefore, it is often appropriate to discuss baseline data. For example, about one-third of the U.S. population is considered overweight. In such a situation it makes no sense (as the client quickly agrees in most cases) to account for each overeater's problem in terms of something peculiarly wrong with that person. We must look at common, underlying factors.

Third, then, we might discuss socialization. While we must consider gender, subculture, age cohort and social location, we are especially interested in common themes for common problems. Childhood learning is often of this sort: American children learn to reward themselves and make themselves feel better by "having a treat." Of course, since "this" is what we now implicitly believe makes us feel better, whatever "this"happens to be, it tends to work for us: it is a matter of our definition of the situation.[2]

Fourth, it is useful to discuss lifestyle factors. In contradiction to "wholistic health" pundits, one's lifestyle is not primarily a matter of free choice but, rather, a consequence of social group, status, occupation, subculture and other social arrangements (Weber, 1946). Our American lifestyles are less chosen than thrust upon us. Our circumstances are stressful, marked by unceasing rapid change in everything from consumer products to relation-

ships, unprecedented role strains, an onrushing stream of often conflicting demands, pressures, threats and information.

Additionally, two background aspects of lifestyle are particularly important to the overeating case. First, as with so many human groups, rituals of social eating are deeply embedded in our culture and are almost mandatory in finding a mate, keeping a job or just "having fun." Second "having something to eat" is probably the only sensual gratification considered wholesome and acceptable for any member of society at any time by almost all subcultures.

At this point it is useful to bring up the concept of *stress,* in both its colloquial and technical usages. In threatening and conflictual situations, we tend to both feel subjectively "up tight" and also to exhibit a psycho-physiological "generalized stress response" with its various insidious consequences (Selye, 1974).

Fifth, we might discuss situational factors specifically affecting the particular case. These might involve his or her job, family relationships, physical handicap or illness, social class, age or any other "social feature" described by Glassner and Freedman (1979). Very common among older overeaters, for example, is the situation of being stuck at home all day with one's spouse at work and one's children grown up and gone.

Sixth, we would describe macrosocial factors. These include the social arrangements of our society and, very often, its economic structure. There is, for example, a multi-billion dollar food processing and marketing industry that depends upon ever-increasing consumption by the American public. High-calorie, processed foods are constantly thrust at us with exhortations to eat them, given easy availability and "pushed" with every strategem of persuasion known. Their consumption is socialized behavior—compliance, not deviance.

After going over such factors, we can present an explanatory hypothesis. I have found it expedient to organize the model in terms of how the problem works and how it ties in with what the client is presently doing or not doing.

A very typical analysis for weight loss and many other problems would be as follows, although it is presented to the client in simpler, substantive terms. The subject comes to define it as "only natural" to indulge in some conduct which has or seems to have a direct payoff, typically sensual gratification coupled with relief from stress or discomfort. She/he also defines most positively the things and actions associated with that conduct. The latent consequence of this routine, however, build up until they are no longer perceived as tolerable. Therefore, the subject now defines *what I should do* as not doing

or "resisting the temptation" to engage in that instrumental conduct. The more people strive to enact this new definition of the situation, the worse becomes their cognitive and psychosomatic stress because they are simultaneously maintaining for themselves, and therefore continuously having to block or deny, the original definitions of the situation. Eventually, they resolve this double bind by "compulsively" giving in and doing it anyway (see Haley, 1958).

Thus, overeaters find that the harder they try to diet the worse the temptations become; eventually they find themselves giving in and "compulsively" stuffing themselves. Many describe their situation in terms of "being programmed that way."

RESOLUTION OF THE CASE: IMPLEMENTATION

While the conclusions section of the research report is rarely treated as critically important, the clinician is not interested in suggestions for future research. Rather, from the explanatory model she/he draws a plan of action to resolve the case.

Most interventions will be done in the course of a series of counseling sessions. For example, resolution of typical overeaters' problems will involve the following: a) helping them redefine the meanings held for themselves regarding food and eating; b) training them in new strategies for doing something about stress that do not require eating or suffering; c) training them in new tactics for coping with food and problems generally; d) facilitating their redefinition of themselves with regard to enhancing self-esteem and their sense of self-determinism; e) providing some counseling with regard to nutrition, behavior modification "homework" and necessary social skills; f) if possible inviting their significant others (at least a spouse if such exists) to attend a session during which the client's program of counseling will be explained, the others instructed in how to help facilitate progress and, if necessary, some light "family counseling" provided.

Usually, it is feasible to work with individual clients on a private or group basis; sometimes we need to work jointly with their family or other intimate groups. In some cases this is only appropriate, as in marital counseling and some sexuality counseling (see, for a social behavioral approach to family therapy, Hurvitz, 1979). For other cases such direct interventions are not ap-

propriate. Except for the sociologist licensed and trained to do so or working in a multidisciplinary unit (e.g., Powers, 1979a, b), it is usually necessary to refer medical or psychopathological cases to an appropriate professional.

A more clearly social strategy is called for in yet other cases. Often the client's problem would best be resolved by helping him/her get involved in a peer support or peer counseling group. An older housewife whose kids have grown up and whose husband is seeing younger women might best be served by referral to a women's center, or possibly her minister or rabbi. In many cases the client can be linked up with a self-help group, community agency or other network that can supply social support.

Implementing the plan of action follows the principle that *the way to be changed is to act changed.* However, clients need some help or they would have changed on their own. We can provide them with knowledge of their alternatives, with tactics and strategies for getting what they want or need, and with help in reconstructing their self-limiting realities so that they can let themselves change, succeed and enjoy their lives. The precise techniques used are of little importance so long as they do not harm or degrade clients and do facilitate achievement of their goals.

Clinical sociologists have reported using a variety of techniques drawn from other practices or developed by themselves. These include subject-centered hypnotherapy (Straus, 1979c), interactionist family therapy (Hurvitz, 1979), guided conversation (Powers, 1979a,b), sociodrama and simulations (Glassner and Freedman, 1979), psychomotor therapy (Howe, 1977), etc.

It is more constructive to consider the generic tasks and strategies of social behavioral counseling, which can be treated as a three-step process. In the first, the sociologist *takes control* over the case in order to initiate the process of reality reconstruction. Intensive heterointeraction is employed at this stage, based on the principle that such intense exchanges can so involve the subjects that they can forget about "how they really are" and other definitions of the situation, accept new definitions and identifications and insert them into their flow of self-interactive "talking to themselves" (Straus, 1978).

It is always necessary to begin with what the client can actually do about the situation. However impossible their objective difficulties, they can always change how they think, feel and imagine about their selves and their situation. Thus, in this initial phase of intervention, we work to help the client reconstruct ideas, attitudes, and other definitions of the situation and to let go of those definitions by which they have been blocking themselves. For example, we help the overeater redefine candy as something sweet that one can take

or leave as one chooses; the idea is that "I don't have to crave and eat it, it's just something there, like a napkin or a still life."

We then shift into a second phase of *teaching control.* We shift our focus in the counseling exchange to suggesting tactics which people can use for or by themselves to break out of self-limiting patterns of response, reaction or conduct and deal with situations and others, their private experiences included, so as to not let such things negatively affect them. Always our underlying goal is to show the person how to avoid taking the role of "victim," of a passive object of the action who cannot help but behave in the same old way.

Rather than directing clients to think about action or how they are feeling or what it all means, we show them *how to do something* about what is problematic for them. Ultimately, our goal is to teach them how to exploit their own self-interactions so as to function as more creative actors in the play of life.

On the short term, we show them alternatives (or help them identify their own alternatives) to what they are already doing, whether they have been aware of the fact or not, which ultimately serves to frustrate them. Focus is always on action and teaching the client how to do things or what to do in problem situations – even if these tactics will only work because the client believes they will. Functionally, this provision of new strategies for effective, self-directed action is the most important element of our approach.

In the assessment, for example, eating was identified as an oral strategy for managing stress. Using food, alcohol, tobacco, drugs or even behaviors such as nail biting for this purpose led to undesirable latent consequences. For such cases, counseling sessions are practically concerned with providing alternate strategies for living and coping that will not evoke a chronic, psychosomatic "fight or flight" reaction.

This aspect of intervention has two phases. The first is re-education intended to correct American socialization wherein we learn that the "right way" to cope with situations is to strain and push, *making* rather than *allowing* things to happen. I would teach such clients instead to act when action is appropriate and efficacious and then to let go of the situation and return to a normal, calm state of arousal until the next moment when they can effectively act.

The second phase is to teach the client something to do about his/her stress. Various relaxation strategies are available (e.g., White and Fadiman, 1976) although it has been my preference to train the client in a form of "self-hypnosis" for this purpose.

In this second stage of intervention, other practical tactics are taught as the case warrants. Weight cases are counseled in cooking and making food choices, handling temptations and employing behavioral tactics for managing food intake. Those with study problems are taught study techniques, etc.

In organizing such interventions we should keep in mind, first of all, that the test of our counseling will be in the client's subsequent actions in everyday life, not in how she/he feels about things during or just after the session. Furthermore, our goal is always to help this client adjust to undesired realities, private, material or social, rather than to adjust the client to the way things happen to be.

The final phase of intervention involves progressively *turning over control* to the client. This is essential since our aim is to interfere as little as possible in the client's lifestyle and living, to select the least disruptive, least coercive and least extensive interventions necessary to get the particular situation resolved. Therefore, we must get ourselves out of the case as soon and as completely as possible.

These goals are facilitated by extending the training in self-management strategies to providing partly-ritual and partly-instrumental *practices* by which clients can take over the active management of their own cases, periodically reinforce their sense of self-control, remind themselves of their new definitions of the situation (and/or create further definitions as they feel appropriate), and otherwise maintain the benefits received from our counseling. Such practices may be either private or social (Straus, 1977).

Social strategies may involve attending periodic group meetings, getting together with others who have similarly solved their problems on a less formal basis, or even joining a community or commune — although this last strategy is rarely employed by secular counselors. Social forms will generally be in addition to private maintenance practices.

As mentioned earlier, in my own practice I generally rely on "self-hypnosis" for this purpose — in conjunction, of course, with following an acceptable eating regimen for weight control cases. Such cases would be asked to "give themselves a session" lasting from a few minutes to a half hour as they desired at least once or twice daily. The technique was designed to both relax the clients and to get them to explicitly remind themselves that "I can be relaxed and I can be strong; I can refuse to overeat and make myself fat."

The principle behind this particular tactic has been called the "law of concentrated attention" (Kroger, 1977: 48). At first we must think about and

deliberately follow new ideas for thinking and acting. However, if we repeat or re-enact them frequently enough over long enough a time, they become so familiar to us as to seem natural, unremarkable, "what we do." Thus, by this constant reiteration in their self-hypnosis practice (usually coupled with the in a multidisciplinary unit (e.g., Powers, 1979a,b), it is usually necessary to refer medical or psychopathological cases to an appropriate professional. client's visualizing him/herself acting in such a way), these new realities become a matter of habit, to be enacted routinely, without necessity of thinking about it, in the course of everyday life.

In concluding discussion of social behavioral interventions, it is exceedingly important to again stress that the critical phase of any counseling action occurs in people's subsequent conduct in their everyday life, in their self-interactions, exchanges with others and management of material and social situations or events. This is the hard part of any counseling endeavor.

While clients are provided training in practices for self-management, there is also a very significant social component to maintenance. They are committed to changing their act and strive to do so in their everyday world. This, however, may threaten the definitions of reality held by others who share that world, who may then act to neutralize this threat to their collective reality. Typically, the dieter's friends and family will remark, "What's wrong with you? You're not acting like yourself."

To forestall this sabotage, it is desirable to recruit significant others as helpers and facilitators of the client's progress. This is why I would advise bringing family and/or close friends in for a session, as mentioned earlier.

However, if clients will persist in enacting their new roles, these others will in time come to interpret that new conduct as literally defining "how they really are." If the subject persists long enough, the significant others will conspire with him/her to maintain the new joint realities.

Until then, two additional ploys may be useful. The client can be given some guidance in making new friends who only know him/her as she/he is trying to be. Alternatively, the counselor may invite ex-clients to participate, as a social practice, in periodic group meetings or social functions for mutual enjoyment and support. Any such networking tactic will be helpful. However, if clients fail to establish supportive relationships of this sort, they will probably fail in their maintenance of the new reality and will require more counseling, give up or find another source of help.

CONCLUSIONS

Unless we recognize the social bases of clients' troubles and the social contingencies surrounding their eventual resolution, we are unlikely to be effective in helping them. This point is already being made for us by other professionals who argue that a sociological perspective can be crucial in organizing the counseling or therapy intervention (e.g., Polak, 1971).

Clinical sociologists claim something beyond this; we claim the right to intervene. In these pages I have sought to demonstrate how interactionist social psychology can be translated into social behavioral counseling strategies. Our tradition provides a unique and consistent rationale for mindwork and many other forms of counseling. We have, therefore, valid grounds for our claim to the legitimacy of clinical sociological practice — as opposed to a questionable situation of presumably untrained social scientists intruding upon the special domain of psychiatry, psychology and other existing counseling professions.

This is not to say that sociologists could and would not benefit from rigorous, multidisciplinary clinical training; the fact is, however, that such has not readily been available to those who have pioneered in this field. All efforts should be made to establish systematic training opportunities for clinical sociologists.

Nor are we in competition with other professionals and seeking to overthrow them. We claim only a unique area of specialized knowledge and competence, and that our professional background can be readily applied to the practical resolution of a wide range of human problems. It remains our task to develop more formally the potentials of this field, systematize practice, and demonstrate empirically that the clinical sociologist has in fact, as well as theory, something of great value to contribute to the counseling sector.

NOTES

1. Earlier versions of this paper were presented at the 1979 and 1980 annual meetings of the Pacific and North Central Sociological Associations.
2. This approach implies a radical reconceptualization of subconscious, psychosomatic and behavioral processes based on pragmatist/symbolic interactionist thinking; experience is mediated by meanings (definitions of the situation) so that it is not the event or object but how

we interpret that object which evokes feelings, reactions, etc. This view implies that definitions of the situation may occur at any level of logical typing (Bateson, 1979) and may, therefore, lie outside normal consciousness. They may, indeed, be timeless and unconscious but, being definitions of the situation, they are at the same time socialized and acculturated. The social dialectic permeates even this level of human functioning.

REFERENCES

Barber, T.X.

1979a Suggested ('hypnotic') behavior: the trance paradigm versus an alternative paradigm. pp. 217-272 in E. Fromm and R. Shor (eds.), Hypnosis: Developments in Research and New Perspectives, 2nd Ed., New York: Aldine.

1979b Training students to use self-suggestions for personal growth: methods and word-by-word instructions. Journal of Suggestive-Accelerative Learning & Teaching, 4/2: 111-128.

Bateson, G.

1979 Mind and Nature. New York: E.P. Dutton.

Beilin, R.

1979 Micropolitical and social control aspects of the clinical practice of sociology. Paper presented at the Annual Meetings of the Pacific Sociological Assn., Anaheim.

Berger, P. and T. Luckmann

1967 The Social Construction of Reality. Garden City, N.Y.: Doubleday-Anchor.

Blumer, H.

1969 Symbolic Interaction. Englewood Cliffs, N.J.: Prentice-Hall.

Coombs, R.H.

1980 Family strengthening to redirect drug-prone youth. Paper presented at the Annual Meetings of the Clinical Sociology Association, N.Y.C.

Douglas, J.

1976 Investigative Social Research. Beverly Hills, CA: Sage.

Glassner, B. and J. Freedman.

1979 Clinical Sociology. New York: Longman.

Goffman, E.

1959 The Presentation of Self in Everyday Life. Garden City, N.Y.: Doubleday-Anchor.

Haley, J.

1958 An interactional explanation of hypnosis. American Journal of Clinical Hypnosis. 1: 41-57.

Howe, L.P.

1977 Psychomotor: A symbolic interactionist form of socio-physio-psychotherapy. MSA Newsletter. Summer. Revised version distributed by Psychomotor Institute, Inc., Boston, 1978.

Hurvitz, N.

1970 Interaction hypotheses in marriage counseling. The Family Coordinator. 19: 64-75.

1979 The sociologist as marriage and family therapist. American Behavioral Scientist. 22/4: 557-576.

Kroger, W.

1977 Clinical and Experimental Hypnosis. 2nd. Ed. Philadelphia: J.B. Lippincott.

Lofland, J.

1976 Doing Social Life. New York: Wiley-Interscience.

Mead, G.H.
1934 Mind, Self and Society. C. Morris (ed.), Chicago: University of Chicago Press.
Polak, P.
1971 Social systems intervention. Archives of General Psychiatry. 25 (August): 110-117.
Powers, S.
1979a The role of clinical sociologist in a multispecialty health facility. American Behavioral Scientist. 22/4: 543:556.
1979b Clinical sociological treatment of a chronic slasher. Case Analysis. 1/3: 169-180.
Sapir, E.
1949 Selected Writings. Berkeley: University of California Press.
Sarbin, T.R.
1977 Contextualism: a world view for modern psychology. In A. Landfield (ed), pp. 1-41. Nebraska Symposium on Motivation (V. 25). Lincoln, NB: University of Nebraska Press.
Sarbin, T.R. and W.C. Coe
1972 Hypnosis: a Social-Psychological Analysis of Influence Communication. New York: Holt, Rinehart and Winston.
Selye, H.
1974 Stress without Distress. Philadelphia: J.B. Lippincott.
Skinner, B.F.
1953 Science and Human Behavior. New York: Free Press.
Straus, R.
1977 The Life Change Process: Weight Loss and Other Enterprises of Personal Transformation. Ph.D. Dissertation, University of California at Davis.
1978 Hypnosis as reality reconstruction. Pacific Sociological Review, 21/4: 407-422.
1979a (Ed.) Clinical Sociology, special issue of American Behavioral Scientist 22/4.
1979b Clinical sociology: an idea whose time has come . . . again," Sociological Practice 3/1: 21-43.
1979c Doing clinical sociology in behavioral counseling: a model weight management program. Case Analysis 1/3: 181-201.
Strategic Self-Hypnosis, Englewood Cliffs, N.J.: Prentice-Hall. Forthcoming.
Thomas, W.I.
1931 The Unadjusted Girl. Boston: Little, Brown and Company.
Weber, M.
1946 From Max Weber: Essays in Sociology. H. Girth and C.W. Mills (eds.), New York: Oxford University Press.
White, J. and J. Fadiman (eds.)
1976 Relax. New York: the Confucian Press.
Wirth, L.
1931 Clinical Sociology. American Journal of Sociology. 37: 49-66.