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ABSTRACT

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

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

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

(cf. Straus 1979a) to tease out the underlying logic of approach characterizing the specifically *sociological intervention.*

In this paper, then, I shall state my findings that, on the basis of analyzing the published and unpublished literature of the field, the sociological intervention may be characterized as (1) directed at the operational definition of the situation, in such a way as to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

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

Operational Definition of the Situation

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

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

> actors not only respond to situations, but also mold and create them. . . . The interactions of participants define the situation. The

units of interest are not individuals, nor organisms, not assemblages
of traits, but *interacting persons* in identifiable contexts.

It is the pattern of these interactions that corresponds to the operational
definition of the situation and that is the target of sociological invtervention.

Levels of Social Context

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

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

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

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

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

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

The Sociological Intervention

If we identify the operational definition with the target of intervention, this scheme generates the following taxonomy of sociological intervention:[1]

Level of Participation	Target of Intervention
Persons	Conduct
Groups	Role Structure
Organizations	Institutions
Worlds	Culture

The intervention itself will, in one way or another, involve a strategy of redefining the situation. At the personal level, for example, sociological counseling might involve reconstruction of the client's assumptive realities and/or social-behavioral tactics specifically designed to change his or her conduct in everyday life (Straus 1979b). Unlike more conventional "psychological" or "psychosocial" counseling, only minimal attention would be placed upon intrapsychic constructs such as defense mechanisms or personality traits. On the other hand, integration of levels of focus leads the sociologist to approach a

person's difficulties at this personal level as *social problems* intimately tied to cultural and subcultural factors, location in history and society, reference groups, family dynamics, and the social construction of reality. Straus (1979b) has shown how, for example, obesity can be managed through a specifically sociological intervention.

Modes of Intervention

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

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

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

Indirect attack is more typical of sociological intervention as practiced by clinical sociologists; the problem is resolved by directing redefinition efforts at higher and/or lower levels of social participation than that at which the identified problem lies. Cheek and Baker (1977) found that subject resistance and ethical problems associated with resocialization programs for prison inmates could be avoided by organizing "self-control training" programs for inmates. This

created the latent function of reducing recidivism—the identified problem—
which occurs at the organizational level of the criminal justice system.

Cooperative intervention tends to be favored in principle by clinical sociolo-
gists. In this mode the client's active participation in the change process be-
comes the key feature of the intervention (Lippitt and Lippitt 1978). Those who
will be affected by the intervention are helped to participate in or even take
primary responsibility for making decisions about and implementing the redefi-
nition process; the role of the sociologist becomes, more than anything else,
that of a facilitator (Glass 1981).

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

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

The Personal Level

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

Even though most practitioners working at this level are associated with the
microsociological paradigm of the Chicago School, they focus upon the person
as member of society and not just as "an individual" with private problems.
They employ a social perspective in analysis and design of intervention that
focuses upon (1) the client's actual conduct in everyday life; (2) the internalized
sociocultural realities that frame and organize that conduct; and (3) the relation-
ship between these realities, the person's conduct, and his or her situation in
terms of the various levels of social context (Powers 1979a, b; Straus 1979b).
Sociological interventions, whether direct or indirect, may often take clearly
social forms, as in directing clients to appropriate community support networks
to reinforce their definitions of the situation, or to peer self-help groups to help

them reconstruct their realities outside of a therapy framework (Glassner and Freedman 1979; Straus 1982).

Indirect approaches more clearly illustrate the special features of a sociological approach at this level. Coombs (1980) describes a drug and alcohol abuse prevention program offering a dramatic alternative to conventional asocial models which seek to scare youths away from experimentation or to treat identified users on the presumption that only sick, deviant, or deficient personalities become abusers. His approach is aimed at individuals who are in a marginal position and are likely to adopt substance-abusing identities—generally those of junior-high-school age. Coombs intervenes by working with the family groups of identified marginal youth so as to enhance family solidarity, keep the family as the youth's primary reference group (rather than drug-abusing peers), and remedy deficits in family skills such as communication, doing things together, or working as a group. Thus, the goal of defining the subject's conduct in a prosocial direction is accomplished indirectly, through what Coombs calls "family strengthening." In this kind of program, the indirect attack becomes the sociologist's primary tactic. Minimal attention is given to substance abuse itself or to correcting antisocial behavior; these are dealt with through indirect intervention at the group level.

The Group Level

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

A direct sociological intervention might be exemplified by William Foote Whyte's solution to a restaurant chain's problems of inefficiency, worker dissatisfaction, and high turnover. He found that there were problems in the role structure of these restaurants. Waitresses, who were women, were placed in a position of giving orders to the higher-status cooks, who were male: those of relatively lower status were giving orders to their nominal superiors, a problem compounded by a violation of gender roles then current in American culture. Whyte's solution was to resolve role strain by a simple mechanical expedient: employment of rotating metal bands with clips on them—known as "spindles"—which allowed waitresses to post their orders in systematic fashion

without having to convey them verbally to the male cooks. The changes incurred by this intervention were so dramatic that something of the sort has become standard throughout the industry. Note how this intervention related the role structure of the group to the broader norms governing conduct in the general society.

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

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

The Organizational Level

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

Direct tactics, although often too straightforward, can be effective. For example, Trist (1981) describes an intervention in the Norwegian shipping industry. Onboard facilities were redesigned to promote a sense of community among the various crew and officer groups who must live together under isolated conditions twenty-four hours a day over extended periods of time. Redefinition

of the shipboard environment to facilitate this new pattern of social relations included creating common recreation rooms and dining halls where all ranks and ratings could mingle (normally each group ate and socialized independently in status-graded facilities); integrating deck and engine room crew; and reducing status differentials between officers and crew.

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

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

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

The World Level

At the highest scale we are considering, that of social worlds, sociological interventions can take even more complex forms. For Lee (1979) the direct approach at this most macrosocial level is identified with humanistically framed, change-oriented research; he views the sociological clinician as seeking to

understand through first-hand materials how socially organized situations actually function and how they can be influenced; he then suggests practical strategies for modifying or coping with problematic social realities, trends, and developments. His work has included the study of propaganda in our society with the goal of sensitizing the broad public to the problem and generating the necessary consciousness to defend them from this kind of manipulation. Significantly, his major work on the subject was published in 1952, during the rise of the cold war mentality and rapid expansion of the advertising profession. Clearly his intent was to generate cultural defenses against the manipulation of society by elites.

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

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

This campaign, designed exclusively by psychologists and "applied behavioral scientists," illustrates as well some of the pitfalls stemming from exclusion of sociologists from organizing and implementing sociological intervention. In this case, the "cultural approach" historically associated with clinical sociology (Wirth 1931) would have had dramatic impact. Instead, the beautifully designed and printed workbooks stressed the interests of "hip" humanistic psychologists—alternative life styles, consciousness-raising groups, and new games. They were also written so as to require a high level of literacy and intellectual orientation. In effect, they might have been designed to be rejected by rural,

working-class, and poor people; businessmen; and conservatives: most of the population, in fact. The materials also evidenced no awareness on the part of their producers of the long-term macrosocial changes underlying the disruption of traditional support networks and primary group structures, leaving the impression that alienation from significant others was a purely individual matter, entirely correctable by personal action.

Between-Levels Intervention

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

Conclusion

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

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

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

Notes

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

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