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ABSTRACT

Clinical sociologists can play an important role in understanding and treating psychiatric disorders They can provide insight into the linguistic and emotional processes that form social psychological pathways to disorders; they can illuminate the sociocultural contexts from which certain disorders emerge and on which they have an impact; and they can facilitate individual and social change A permanent place for clinical sociology in the therapeutic community of a psychiatric facility will not be created, however, without the interdisciplinary adoption of a unifying conceptual framework in which biological, psychological, and sociological factors are defined as of potentially equal importance in the development of psychiatric disorders.

What can clinical sociology contribute to the therapeutic community of a psychiatric facility? Does it add just one more discipline to the plethora of professionals serving individuals with psychiatric disorders; [1] and bring one more variable—social factors—into an established medical perspective on the origin and consequences of mental illness? Or can it make a valuable contribution in its own right as an essential element in a comprehensive, biopsychosocial approach to understanding and treating psychiatric disorders.

These questions will be answered from the standpoint of a clinical sociologist who recently completed a two-year training program at a psychiatric hospital and medical center. In the process of working in the hospital setting, familiarity was gained with the general perspectives and treatment strategies of the various professionals involved in inpatient and outpatient care. The opportunity also existed to apply sociological insight and skills as a researcher and clinician. During the two-year program close contact was maintained with over seventy-five patients who were part of an ongoing, longitudinal study of manic depressives:

individual, couples, and family therapy was provided to numerous patients with psychiatric disorders, and two groups were co-led—one made up of manic-depressive outpatients and the other of the family members and significant others of manic depressives.

The following sections will (1) describe the evaluation procedures and treatment strategies generally followed in the hospital setting; (2) suggest a conceptual framework from which clinical sociologists can assess and treat patients and their significant others; and (3) discuss how adopting such a framework can facilitate a therapeutic community based on mutual understanding and complementary roles.

Traditional Evaluation and Treatment in a Psychiatric Setting

In its ideal form, therapy involves establishing a climate of trust and empathetic understanding to achieve insight into the individual who is experiencing a particular problem. The therapist then uses that insight to facilitate, in partnership with the individual, constructive change. Change may entail the promotion of differences in the ways individuals perceive, interpret, feel, or behave in relation to their environment, or it can involve the transformation of particular social circumstances, such as family context, work situations, or financial position. In either case, the therapist focuses on creating a difference in the individual/society relationship.

In the emergency room or walk-in clinic of a psychiatric hospital, the individual—designated "patient" by hospital personnel—often presents in a disordered crisis state, necessitating the temporary setting-aside of any ideal therapeutic process while the professional staff assists the patient in regaining a sense of control and stability. This is usually done through the use of established procedures for quickly and efficiently evaluating and diagnosing the patient for treatment purposes. Accordingly, information gathering is primarily focused on the patient's current status. Is the affect of normal range and intensity, or is it constricted? Is speech goal-directed or pressured and abnormal in rate? Are there auditory hallucinations, delusions, or suicidal plans? Is the patient alert and oriented, able to remember three of three objects in five minutes, or does he have difficulty noting similarities and conceptualizing abstractions? Evaluating the present and ongoing status of the patient is crucial to preventing danger to both the individual and community members and provides a basis for utilizing established techniques, primarily pharmacotherapy, to reduce symptomatology and assist the patient in returning to a stabilized or normal state.

Emphasis on diagnosing psychopathology, monitoring symptoms of illness, and pharmacological treatment continues throughout inpatient hospitalization and often after the patient is transferred to a day hospital or outpatient setting. This emphasis is reflected in the type and amount of information contained in

patient charts. Current status and course of illness are well documented, and information on the patient's medical history is detailed and extensive, including data on childhood illnesses, immunizations, allergies, drug and alcohol habits, hospitalizations, and foreign travel. Psychological material is typically restricted to the results of optional testing procedures or brief comments on the patient's status and behavior as observed in individual or group therapy sessions. Sections on social history note biographical data such as marital status or sexual orientation, where the patient was born, raised, and educated, the number of family members, and any medical or psychiatric illnesses in first- or second-degree relatives. More recently, with the emergence of social support as an important mediating variable in psychiatric disorders, major social relationships and resources are also noted.

Overall, the dominant perspective on the patient is medical with biological processes being the major target of examination and control. Social psychological factors are included but in a basically adjunctive fashion. Within this context, treatment primarily consists of periodic followups with a psychiatric resident for medication and illness checks, case management by a social worker, and participation in various therapy groups designed to maintain or improve the patient's biological and social functioning.

In a therapeutic setting dominated by a medical perspective, clinical sociologists can learn to recognize and evaluate the symptoms of acute episodes and chronic disorders. They can also become aware of the physical traumas, diseases, alcohol or drug ingestion, and neurophysiological abnormalities that can serve as pathways to psychiatric disorders. In addition, they can come to appreciate the circumstances in which traditional psychiatric treatments, such as electroconvulsive therapy or medication, are necessary and important. They cannot, however, within a perspective placing primary focus on biological processes and pharmacotherapy, play a truly interdisciplinary role. Such a role depends on the acceptance of a conceptual framework that defines psychological, sociological, and biological factors as of *potentially* equal importance in the emergence and consequences of disorder. Only then can alternative pathways to disorder and their intersection be accurately assessed and appropriate treatment strategies formulated.

From a biopsychosocial standpoint, clinical sociologists can use their investigative and analytical skills to identify the social-psychological processes and sociocultural contexts through which particular patterns of thinking, feeling, and behaving develop. With their knowledge of social identities, interactional processes, and social norms, beliefs, and values, they can predict the social consequences of certain behaviors. In addition, their sociological knowledge and skills can be utilized to create effective strategies for facilitating personal and social change. Moreover, a clinical sociological perspective need not eliminate the importance of biological factors or diminish the knowledge and skills of

other disciplines, such as medicine, psychology, or social work. Neither does it discount the usefulness of medication, especially in times of crisis or in cases of severe neurological or physiological dysfunction. It does enable a more in-depth and comprehensive approach to understanding, treating, and preventing psychiatric disorders.

The Contributions of Clinical Sociology

Clinical sociologists have the methodological skills and experience for establishing and maintaining rapport with individuals, for doing in-depth interviewing, and for completing individual profiles, historical analyses, and case studies. They also have the skills necessary for organizing and analyzing the data elicited not only for the individual concerned but across groups of individuals. Of particular importance for work with patients and their significant others is the concern of clinical sociologists with understanding and illuminating *meaningful* behavior. That is, through the use of *verstehen,* as introduced by Max Weber and developed in the sociological schools of dramaturgical social psychology and symbolic interaction, they can attempt to understand how individuals formulate and make sense of their personal and social realities.

Understanding through Language

Understanding the patient's point of view or standpoint, no matter how divergent it may be, involves developing an understanding of how the patient typically perceives and conceptualizes his social and physical reality. One of the major ways individuals make sense of themselves and their environment is through language. They use specific culturally-influenced vocabularies to construct meaning. They take into account and evaluate particular personal characteristics, relationships, and events; attribute meaning to circumstances and occurrences; and, most importantly, continually make definitions of the situation or *composite generalizations* about their self/environment relationships. Sociologists, accustomed to participant observation and "taking the role of the other," are proficient in discerning "the language of situations as given" that Mills (1975:169) advised "must be considered a valuable portion of the data to be interpreted and related to their conditions." In working with psychiatric patients on an outpatient basis, a grounded theory approach (Glaser and Strauss, 1967) can be used to uncover the typical linguistic forms and processes through which patients develop, express, and negotiate composite generalizations regarding their relationships to the environment. Over a series of sessions and contexts a patient's primary linguistic vocabularies and statements can be identified as well as the relationship of those vocabularies and statements to particular, recurring generalizations. Many manic depressives, for example, repeatedly

define situations involving responsibility, evaluation, or performance as "ordeals," "burdens," or "possible threats." Uncovering such recurring generalizations, the processes through which they are constructed, and the social and cultural contexts through which they emerge and are maintained provides a basis for understanding patients' emotions and behavior.

Understanding through Emotion

Identifying and validating the recurring composite generalizations through which patients define their self/environment relationships can lead to the identification of specific emotions routinely connected to particular generalizations. In my experience, for example, anxiety was repeatedly connected to patients' defining their relationship to the environment as one of possible vulnerability to threat. Anger was continually linked with conclusions that their situation relative to the environment was unfair, unjust, or intolerable. In this respect, emotions appeared to be the physiologically experienced counterparts of specific composite linguistic generalizations. Therefore, like language, they were an important means for individuals to know, understand, and respond to their environment, a position supported by Finkelstein (1980:119), who states that emotions are "stances toward the world, emblematic of the individual's apprehension of it and moral position within it"; Kemper (1978:47), who asserts that emotions are evaluative responses; and Averill (1980:305), who depicts emotions as "improvisations, based on an individual's interpretation of the situation."

This conceptualization of emotion provides an area of understanding inclusive of, yet beyond, the traditional psychiatric focus on emotion as an irrational response or as a symptom of psychopathology. And it provides the basis for identifying typical, recurring *emotional repertoires* or sets of emotion within a single patient or group of patients and uncovering important relationships among particular composite generalizations, linked emotional repertoires, and behavior. Of specific importance among psychiatric patients was the uncovering of patterns not generally prevalent in form, degree, or intensity among nonpsychiatrically disordered individuals.

Apart from identifying typical emotional repertoires and their linguistic and behavioral correlates, clinical sociologists can draw upon their knowledge of the sociology of emotions to develop further understandings and treatment strategies. They can explore variations in how patients *experience* emotion, and they can study how patients typically *objectify*—take into account and make sense of—their own emotions and the emotions of others. A focus on objectification may uncover unusual patterns of emotional attribution and evaluation as well as the inability or disinclination to perceive, label, or evaluate specific emotions. Clinical sociologists may also examine patterns of *emotion management,*

a process called self-upon-self and self-upon-other emotion work by Hochschild (1979:562). Exploring patients' emotion management strategies can provide critical insight into important identities they wish to establish or prevent; destructive patterns of emotional monitoring or manipulation; the distancing or control of emotion through the use of drugs or alcohol; and, often, the inability to manage emotional reactions. A clinical sociologist's knowledge of cultural differences also enables the identification of emotion management processes intrinsic to specific subgroups, precluding certain individuals (e.g., those with special ethnic identities), from being unfairly labeled disordered or deviant.

In addition, clinical sociologists may trace the *emotional career*—the process through which particular emotions emerge, intersect, are maintained, altered or diminished, of a particular emotion or set of emotions—enabling insight into processes like the development of controversy between patients and their significant others or the emergence of apathy in a support group. They may discern how emotions are incorporated into negotiation processes (Sugrue, 1982), a practice occurring, for instance, when a manic-depressive patient and family member disagree over an emotion being a normal reaction or a sign of an impending episode. *Expressed emotion,* as displayed in verbal and nonverbal forms, and *exquisite emotional sensitivities* or propensities to be intensely reactive to particular events, individuals, or circumstances, are other areas of sociological concern.

Understanding Behavior

Identifying an individual's typical composite generalizations and linked emotions can lead to understandings of important behavioral patterns like aggression, withdrawal, or suicide attempts. From the standpoint of ongoing anxiety and a continual lack of positive emotion, for example, patients may withdraw, creating private, idiosyncratic realities in which they obtain serenity and satisfaction. Or, from the standpoint of ongoing frustration over a lack of status at work, one may, in the safe environment of his home, act abusively toward his wife and children. The major issue in a psychiatric setting is to identify standpoints and behaviors that are particularly divergent or personally and socially destructive.

Society in the Individual and the Individual in Society

Achieving insight into the linguistic, emotional, and behavioral patterns of psychiatric patients with mild to severe disorders leads the clinical sociologist to a critical, related task—uncovering the sociocultural contexts within which patterns emerge and are maintained or altered and identifying the consequences of particular patterns for the patient and society.

Clinical sociologists are well qualified to uncover for the patient, family members, and mental health professionals the important *interpersonal* and *sociocultural contexts* within which patterns of thinking, feeling, and behaving develop and upon which they have an impact, a fact critical to both understanding and treatment. Sociologists are often familiar with the cultural beliefs, norms, and values of the general society as well as those of specific ethnic groups, age cohorts, or social classes. They can therefore draw attention to the sociocultural funds of knowledge from which individual and collective meanings emerge. They can discern relationships among certain sociocultural contexts, particular linguistic/emotional patterns, and types of disorder. They can also point out patterns of behavior that may appear divergent but which are actually normative for particular groups or organizations. Furthermore, they can often predict what types of behavior will have serious social consequences.

One important and well-known social context with which the sociologist is familiar is the *family context*. During contact with family members in interview and group settings and with information elicited from patients, the clinical sociologist can note family themes, practices, or interactions that contribute to or maintain specific linguistic, emotional, or behavioral patterns. This information is often vital for facilitating positive change within the patient or family. It is also of great value in designing or leading family support groups.

In the process of working with patients and their families, the clinical sociologist may also discover pertinent *transgenerational contexts*, that is, extended family histories of psychiatric disorder, alcoholism, drug abuse, violence, trauma, or patterns of behavior represented in the patient by exquisite emotional sensitivities or divergent perceptual and linguistic processes or behaviors. That some of those sensitivities or divergent processes may have a genetic basis or biological significance does not negate their social psychological relevance or impact.

Familiarity with social roles, interpersonal and group behavior, and the intricacies of organizations also enables clinical sociologists to suggest what circumstances or settings may be especially threatening or frustrating to a particular patient or group of patients. In addition, they may propose suitable settings or procedures for reintegrating patients into society.

Understanding society, the individual, and the interface between them is an important contribution of clinical sociology. It is especially vital in the case of psychiatric patients as their relationship to society is often tenuous, explosive, or alienated.

Doing Therapy or Facilitating Change

It has been stated that clinical sociologists are able to identify both normative and divergent patterns of thinking, feeling, and behaving. It has also been

pointed out that they are skilled at understanding and describing the sociocultural contexts within which specific patterns develop and upon which they have an impact. These understandings form the basis of the clinical sociologist's ability to facilitate individual and social change.

Skilled in understanding interpersonal interaction and group processes, clinical sociologists can use individual, couples, family, or group settings as arenas for promoting awareness of particular linguistic, emotional, and behavioral patterns and their personal and social consequences. In individual and group sessions they can facilitate patients' recognition, understanding, and alteration of taken-for-granted linguistic patterns and processes, composite generalizations, and their emotional and behavioral correlates. For example, patients may reach the point, often labeled "paranoid," where they refer to most of their life situations as possibly threatening. At the same time they may be continually perceiving themselves as highly vulnerable to the possible threat and as having little, if any, possibility of achieving control over their vulnerability or the threat. As a consequence, these patients will probably experience considerable anxiety, the emotional experience linked to the composite generalization, possible vulnerability to threat. Recognizing the generalizing behavior and understanding the contexts through which it made sense to the patient to develop it—perhaps a particularly traumatic event or a series of personal catastrophes—could be the first step toward the patient transforming the behavior. In this case, clinical sociologists might assist patients in recognizing and understanding this generalizing behavior and its consequences; redefining certain current circumstances as nonthreatening; altering, where possible, situations perceived as especially upsetting; placing previous events in a new, nonthreatening, conceptual framework; viewing themselves as less vulnerable; or achieving more confidence in their ability to control anxiety-provoking circumstances. The clinical sociologists might also help the patient learn to manage anxious responses or modify any obsessive or withdrawing behavior related to feelings of vulnerability. They might work with patients in a support group, encourage family members to view patients as less vulnerable, or request the assistance of an occupational or art therapist to reinforce anxiety-lessening habits. In addition, the aid of a physician might be enlisted to provide a tranquilizer for situations when the patient feels unable to tolerate an extreme anxiety reaction.

In family and couples sessions, clinical sociologists can assist patients and significant others in identifying especially destructive interpersonal patterns and provide suggestions and support for developing and practicing new behaviors. Within group sessions they can create opportunities for patients to identify their routine means of defining as well as responding to social circumstances and promote a safe, collective context for the control or alteration of emotional vulnerabilities and undesirable behaviors.

The clinical sociologists' knowledge of social norms and values serves an

important therapeutic function. In individual and joint sessions they can assist patients in the identification of cultural values that influence personal beliefs and feelings or create desirable and undesirable identities. They can advise patients on likely contradictions between personal goals and societal possibilities and assist patients in finding or creating unique opportunities within established social organizations and systems. They can also help patients and family members understand and deal with disorder-related stigmatization.

Psychiatric disorders provide a particularly compelling opportunity for clinical sociologists to teach patients ways to interface effectively with their social environments. Understanding both sides—individual and society—enables clinical sociologists to appreciate specific individual vulnerabilities and their likely relationship to environmental circumstances. Accordingly, they may develop, with the patient, creative means for navigating the social system, whether that system is the workplace, a social gathering, or a hospital setting. Through social skills training or resocialization techniques, they can assist individuals in making and maintaining the roles they desire or in setting aside destructive or unfulfilling roles. Fein (1988) provides an excellent example of this process in his discussion of social role change. Furthermore, his case discussion of Robert (Fein, 1988:95–97) illustrates the major importance of emotional resocialization in the therapeutic process.

Finally, clinical sociologists have the broader therapeutic task of identifying for the community those beliefs and values that underlie social structures, institutions, and practices. It is those structures, institutions, and practices that form the context within which certain individuals achieve social integration while others achieve only isolation and rejection. Within a particular society or group, who is given status and respect? And for what characteristics or accomplishments? Which individuals or groups are defined as outsiders? And for what attributes or behaviors? Furthermore, does society grant prestige and a favorable position to psychiatric patients who make small but critical gains or who remain stable despite extreme emotional sensitivities, and does it provide a place besides welfare for individuals who can only be minimally productive? The answering of such questions by society members may promote the social change necessary to reduce the number of individuals who intersect with their social environment in an angry, destructive manner or withdraw in isolation to their unique, but more acceptable, realities.

Conclusion: The Therapeutic Community

It has been argued that clinical sociologists can play an important and valuable role in understanding and treating psychiatric disorders. The implementation and maintenance of that role, however, will not only depend on patients, family members, and significant others defining clinical sociology as

therapeutically valuable. It will be based on the interdisciplinary adoption of a unifying conceptual framework within which biological, psychological, and sociological factors are defined as equally important in the emergence and development of psychiatric disorders. A model based on psychopathology and the primacy of biological factors does not allow that equality, but a model based on understanding and focused on the perspective of patients and their linguistic, emotional, and behavioral patterns does. Such a model does not neglect neurophysiological or biochemical processes; it simply conceptualizes those processes as integrally linked in an identifiable fashion to typical composite generalizations and emotional/behavioral responses. Accordingly, in some cases destructive behavior or explosive emotional responses may be primarily based on the habitually used linguistic patterns through which patients construct generalizations about their self/environment relationships. In other cases, the predominant pathway to divergent beliefs, intense emotionality, or erratic behavior may be linked to biochemical abnormalities or neurological deficits. At times medication may be necessary to control destructive behavior, soften intense emotional reactivity, or supplement organic deficits. On the other hand, social or psychological therapies may prevent or alter the formation of particular generalizations and linked emotional and behavioral responses, making unnecessary the sometimes harmful side effects of pharmacotherapy.

Overall, from the standpoint of a conceptual framework based on the equal and intersecting relevance of biological, social, and psychological factors and focused on understanding the definitions and standpoints of patients and their significant others, clinical sociology has an important and viable place in the therapeutic community. In fact, it is an essential part of a necessary whole. As stated by Straus (1979:24–25)

> . . . clinical sociology is not something that can or should stand alone or in adversary relationship either to other forms of academic social science or other clinical disciplines. Rather, our ultimate goal is and must be the establishment of a unified clinical social science, within which sociologists, psychologists, anthropologists and those with interdisciplinary orientations of various sorts can take their rightful place. The question is not to demonstrate the uniqueness and superiority of a clinical sociology, but to show how sociologists can provide a valuable contribution to the field of clinical practice due to our in-depth grounding in sociological perspective, method, concept and imagination.

Within a psychiatric setting, above all others, it is imperative to understand those special individuals who, from the standpoint of specific vulnerabilities, circumstances, or ways of defining and interacting, have found themselves lost

from or at war with normative society. Understanding how a particular individual/society linkage becomes broken or destructive and facilitating its repair requires the exploration of biological, psychological, and sociological patterns and processes. It also calls for the dedication and skill of professionals from diverse disciplines. In essence, a community is that which carries on a shared way of life and exhibits interdependence. Within the context of a shared conceptual framework, each discipline can contribute its own expertise yet recognize its limits of understanding. In the process, a truly interdisciplinary and therapeutic community will be created.

NOTES

1 I have used the terms "psychiatric disorder," "patient," and "psychiatric setting" since these were the terms generally used in the hospital environment. My personal preference as a clinical sociologist, however, would be to refer to "adaptive disorder," "individual," and "treatment setting."

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